San Diego Countywide Strategic HIV/AIDS Housing Plan

October 1999

Vision, Mission, and Values

San Diego County HIV Housing System

Adopted May 1999

Vision

A future where all people living with HIV achieve and sustain an optimal quality of life.

Mission

To assure the creation and accessibility of affordable housing and services for our diverse HIV infected, affected, and at-risk communities.

Statement of Shared Values

- We value each individual and uphold their right to their beliefs and values.
- We respect diversity and do not tolerate discrimination.
- We value the broadest possible representation from among the HIV affected communities.
- We believe all people should have access to supportive services as a basic right.
- We value the efficient delivery and management of HIV housing and services.
- We recognize our responsibility to respond to the changing housing and service needs/priorities within the HIV community.
- We value our responsiveness to and awareness of the expanding face and facets of the HIV/AIDS pandemic both locally and globally.

Executive Summary
San Diego Countywide Strategic HIV/AIDS Housing Plan

The County of San Diego contracted with AIDS Housing of Washington, a Seattle-based nonprofit agency, to conduct a needs assessment and facilitate a planning process leading to the development of an HIV/AIDS housing plan. The needs assessment included: a review of relevant planning documents and epidemiological data; consumer focus groups; site visits to AIDS housing programs; a case manager survey; a survey of affordable housing and AIDS service organizations; and one-on-one interviews with key housing and service providers. In order to assess the housing needs and preferences of consumers, a survey was distributed throughout San Diego County to people living with HIV/AIDS who receive HOPWA assistance.

If you would like to receive a copy of the *San Diego Countywide Strategic HIV/AIDS Housing Plan* and Appendices, please contact the County of San Diego Department of Housing and Community Development at (858) 694-8713.

Purpose of the Plan

The *San Diego Countywide Strategic HIV/AIDS Housing Plan* was initiated by the County of San Diego Department of Housing and Community Development (HCD) with the support of the HIV Housing Committee. HCD determined that a needs assessment, coupled with a Plan, would enable the community and its leaders to better understand HIV/AIDS housing issues, to measure the extent of need for housing assistance for people living with HIV/AIDS (PLWAs), and to determine the best course of action for alleviating the housing problems of PLWAs in the San Diego region.

Introduction

The availability of safe, affordable, and appropriate housing options has been a concern of advocates, service providers, and people living with HIV/AIDS in San Diego County throughout the epidemic. In recent years more households are indicating a need for on going or intermittent financial assistance to secure or maintain adequate housing.

The County of San Diego receives Housing Opportunities for Persons with AIDS (HOPWA) funding directly from the U.S. Department of Housing and Urban Development (HUD). The HOPWA program provides grant funds to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of low-income people living with HIV/AIDS and their families. The County of San Diego Department of Housing and Community Development contracted with AIDS Housing of Washington (AHW) to provide

leadership and consultation in a community-based needs assessment and planning effort.

This planning effort incorporated the input of a wide range of interested community members including people living with HIV/AIDS, representatives of AIDS services and housing organizations, housing developers, members of local government agencies, and the general public. Members of the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee reviewed local housing and epidemiology data, distributed an HIV/AIDS housing consumer survey, identified target populations and arranged consumer and provider focus groups, and identified and affirmed critical issues and recommendations for inclusion in the plan. AHW provided data entry and analysis of the consumer, case manager, and provider survey data; conducted focus groups; facilitated one-on-one housing and service provider interviews; and wrote the plan.

The results of the needs assessment process led to the development of recommendations and strategies intended to strengthen the HIV/AIDS housing system and the larger HIV/AIDS services system, and increase access to appropriate housing resources for people living with HIV/AIDS throughout the county.

The Context of AIDS Housing in San Diego County

This is a challenging time to be engaged in planning housing for people living with HIV/AIDS. Available federal funding, the changing demographics of the population of people living with HIV/AIDS, and advances in AIDS treatment protocols all impact planning for, and the provision of, AIDS housing and supportive services.

People living with HIV/AIDS who are successfully taking anti-retroviral therapies are experiencing significantly improved health and changes in some of the markers used to measure levels of HIV in the blood. The HIV/AIDS housing system now must plan for the housing needs of people who are healthier and living longer, not just those who are severely ill and dying.

At the same time, however, recent studies suggest that as many as 50 percent of the individuals who are treated with protease inhibitors cannot tolerate the drugs, do not respond to them, or eventually decline after a period of positive response. We know that successful treatment with these drugs requires strict adherence to daily medical protocols. Stable housing is extremely important, if not essential, to such compliance. Homeless individuals are less likely to be prescribed protease inhibitors by their doctor because they are often unable to follow such protocols.

Today, there is more uncertainty in the AIDS housing field than ever before, due to changes in the epidemic and the uncertainty of future federal funding. It is within this context of change that the *San Diego Countywide Strategic HIV/AIDS Housing Plan* was developed.

Housing and Homelessness in San Diego County

San Diego County encompasses metropolitan cities, suburban communities, and rural areas. The population of the county grew 12 percent between 1990 and 1998. Forty-four percent of the region's total population resides in the City of San Diego, the other incorporated cities in the County of San Diego comprise 40 percent of the population, and the remaining 16 percent of the population lives in unincorporated areas of the County. Six cities in San Diego County experienced population increases of over 10 percent between 1990 and 1998.[1]

Fourteen percent of County households earned less than $15,000 in 1997, and El Cajon, Escondido, Imperial Beach, and National City had high percentages of residents earning less than $25,000. As in many other metropolitan areas, poverty among racial minorities in San Diego is a significant problem. While the overall percentage of people living in poverty was approximately 13 percent in 1990, the percentage is much higher for most racial minority groups: African Americans (21 percent), Hispanics (23 percent), and other non-Caucasian races (26 percent).

The average monthly rent in San Diego County rose to $739 by the fall of 1998. This represents a 9.2 percent increase over 1997, and a 24 percent increase since 1994. Between the fall of 1997 and the fall of 1998, ten communities experienced rental increases of $100 per more on average for a one-bedroom apartment.

Many of the county's households experience one or more of the following housing problems:

- Overcrowding (9 percent)
- Housing cost burdens, or paying more than 30 percent of your household income on housing costs (41 percent)
- Worst case households, or those earning less than 50 percent of area median income and paying over half of their income on rent, living in substandard housing, or both (75,000 in 1994)[2]

The San Diego Regional Task Force on the Homeless (RTFH) estimates that there are at least 15,000 persons throughout San Diego County who meet the HUD definition of homelessness. Resident farm workers and day laborers comprise more than half of this estimated range. These totals do not include undocumented persons who may be homeless.[3]

HIV/AIDS in San Diego County

As of August 31, 1999, 10,029 cases of AIDS had been reported in San Diego County. Of these cases, 4,219 people are believed to be living with AIDS. An additional estimated 8,000 people are HIV positive yet do not have AIDS.
There is an increasing proportion of reported AIDS cases among Hispanics, African Americans, women, injection drug users, and those who contract the disease through heterosexual contact.

[1] San Diego Association of Governments, *Draft Regional Housing Needs Statement, San Diego Region,* November 1998.
[2] Ibid.
[3] Regional Task Force on the Homeless, *Regional Homelessness Profile*, 1998.

Meanwhile, reported AIDS cases among men who have sex with men and Caucasians are declining.

In San Diego County, cumulative reported AIDS cases have been male dominated (93 percent), yet new cases reported for 1997 and 1998 show that cases reported among women accounted for 10 percent of all cases.

While only 6 percent of the county's total population are African American, 12 percent of cumulative AIDS cases and 17 percent of recent cases have been among this racial group. In addition, Hispanics account for 29 percent of recent AIDS cases yet only 24 percent of the county's total population.

Seventy-seven percent of cumulative reported AIDS cases have been attributed to men having sex with men (MSM), yet that number has declined to 70 percent of recent cases (1997 and 1998). Meanwhile, among recent AIDS cases, more people have attributed their HIV infection to injection drug use (12 percent) and heterosexual sex (8 percent) than cumulative AIDS cases (8 percent and 4 percent, respectively).

The majority of AIDS cases reported in the county have been reported in Central San Diego (65 percent), although that number has declined among recent cases (1/97 to 8/99) to 59 percent. South Bay reported only 8 percent of the cumulative AIDS cases yet 13 percent of recent cases.

Homeless persons living with AIDS in San Diego County are most likely to be African American; male; gay or lesbian; and reside in Central San Diego.

HIV/AIDS Housing Inventory

People living with HIV/AIDS own homes, rent apartments on the open market, live in public or other low-income housing, reside in AIDS and other special needs housing facilities, are doubled-up with friends or family, or are homeless. Clearly, many people living with HIV/AIDS have their housing needs met through non-HIV/AIDS-specific affordable housing programs and will continue to do so even if HIV/AIDS-dedicated resources increase. HIV/AIDS-dedicated housing resources available in the future will not and *cannot* meet the housing needs of all people living with HIV/AIDS.

Many individuals want to remain in their homes but need financial support in order to do so. Ryan White CARE Act funds pay for emergency assistance (EARP), most of which is spent on rents and security deposits. There are 81 to 121 transitional housing beds, 20 Residential Care Facility for the Chronically Ill (RCF-CI) beds, and 63 to 103 permanent supportive housing opportunities. In addition, permanent independent housing is provided by the following rental subsidy programs: the tenant-based rental assistance (TBRA) program provides 100 subsidies, the Partial Assistance Rental Subsidy (PARS) program provides 260 subsidies. Townspeople (8 units) also provides permanent independent housing. Other agencies provide additional housing services, including case management/coordination, moving assistance, and information and referral.

Every community struggles with how to project the amount and types of housing assistance that people living with AIDS need. There is no clear formula for such a calculation. However, the *San Diego Countywide Strategic HIV/AIDS Housing Plan* outlines projected need for HIV/AIDS housing based on a number of potential factors, including income, homelessness, and HIV status. If need were projected by considering the smaller estimates of low-income people living with AIDS, homeless persons, and those who were HIV-positive who needed assistance (2,109 persons) compared to existing housing units/subsidies (532-612) there would be a gap of more than 1,497-1,577 housing units/subsidies.

Consumer Housing Surveys

As part of the San Diego County HIV/AIDS housing planning process, people living with HIV/AIDS who were receiving housing assistance through a HOPWA funded program or facility were surveyed regarding their current and previous living situations, housing needs, and housing preferences. The survey was made available in English and Spanish. A total of 226 completed surveys were returned for analysis.

Despite the fact that the survey respondents were housed, many respondents are clearly in very precarious housing situations. For example, over half of the respondents reported spending more than 30 percent of their income on rent, and nearly one-third reported spending more than 50 percent. In addition, over 50 percent of respondents would have to move if their rent increased by $50, an indicator of being at serious risk of homelessness; and more than 50 percent of respondents earned less than $700 per month.

More than 25 percent of respondents had moved since learning of their HIV status because they were unable to pay the rent, and nearly one in four respondents had moved three times or more in the last three years. In addition, more than half of respondents had slept outdoors, in a car, in a shelter, at a friend's house, or had traded sex for a place to sleep or for rent in the time since they had been diagnosed HIV-positive.

Respondents to this survey are accessing services, specifically housing assistance, yet they continue to have "housing problems" and remain at risk of homelessness. While nearly 75 percent of respondents are comfortable in their current housing situations and would prefer to stay in their current housing if they were to get sicker, most are a small rent increase away from becoming homeless; and for many, it would not be the first time.

Consumer preferences must be considered in determining the need and viability of additional HIV/AIDS-dedicated housing resources. In San Diego County, consumer preference indicates a need for more permanent independent housing units, subsidies and/or services which allow individuals to maintain independence and remain active in their community for as long as possible.

In addition to the survey associated with this Plan, selected results from the 1998 and 1999 HIV/AIDS Needs Assessment Consumer Surveys are included in the Plan.

The 1,322 respondents to the 1999 HIV/AIDS Needs Assessment Consumer Surveys clearly stated that housing and shelter were important and necessary—it was the seventh highest priority service among respondents. The survey also demonstrates that many people living with HIV/AIDS in San Diego County are in need of housing assistance in order to stabilize their lives. Variables such as percent of income spent on housing costs (63 percent spend more than 25 percent of their income on housing); length of time in current housing (24 percent had lived in their current housing for less than 6 months); and history of homelessness (25 percent had been without their own room or house in which to spend the night in the last 12 months), confirm that people are living in unstable housing conditions. In addition, many respondents are mentally ill (13 percent) and/or are current or former substance abusers (59 percent). These results all highlight the need for housing assistance for people living with HIV/AIDS in San Diego County.

The 1998 HIV/AIDS Needs Assessment Consumer Survey results are included in this chapter due its inclusion of multiple housing-related questions not seen in the 1999 HIV/AIDS Needs Assessment Consumer Survey. The selected responses presented here from 1,433 respondents demonstrate that many respondents need rental subsidies (19 percent), have problems finding housing due to discrimination, and have frequently been without a place in which to spend the night in the last 3 years (9 percent had been in this situation 3 or more times). In addition, many respondents had difficulty maintaining their housing due to mental health and drug abuse problems.

Provider and Case Manager Surveys

For the development of the *San Diego Countywide Strategic HIV/AIDS Housing Plan*, approximately 60 housing surveys were distributed throughout the county to case managers, and 80 were distributed to housing providers and AIDS service organizations. The purpose of the surveys was to assess the housing needs of the clients served by housing and service providers and case managers throughout the county. Seventeen case managers and 9 providers responded.

Case managers and housing and service providers clearly stated that their clients do not have enough housing options, especially independent housing and transitional housing options. Transportation, both to services and for use while searching for housing, was cited within the survey and also in many comments on the margins of the surveys as a critical need. Many clients are also in need of alcohol/drug treatment/counseling and meals/nutrition counseling. The identified barriers to housing that clients often face were; the difficulty of the application process, the insufficiency of the subsidy, the lack of knowledge about and/or access to housing assistance, and the lack of options for housing families with children.

Critical Issues

A review of relevant planning and epidemiological documents provided a framework for the needs assessment. The needs assessment included: a review of relevant planning documents and epidemiological data; consumer focus groups; site visits to AIDS housing programs; a case manager survey; a survey of affordable housing and AIDS service organizations; and one-on-one housing and service provider interviews. In addition, a consumer survey was distributed throughout San Diego County to people living with HIV/AIDS who receive HOPWA assistance to assess housing needs and preferences. An overview of critical issues identified through this process is provided below.

System-Wide Issues

Planning, prioritization, and resources allocation together were ranked highest by the Steering Committee, followed closely by activities which will increase the capacity of providers throughout the HIV/AIDS housing and support service continuum. Coordination and collaboration are key components to the success of these endeavors.

1. **Planning, prioritization, and resource allocation**. Community-based needs assessment and planning is needed in order to build a comprehensive continuum of housing and support services, and to assure that existing programs have sufficient funding to adequately address current needs.

2. **AIDS housing provider capacity**. Housing development and operations are complex activities requiring a broad range of skill and knowledge, and many housing providers do not have the capacity to develop AIDS housing facilities.

3. **Involvement of the HIV-infected community**. Consumer input in the planning and decision-making process regarding HIV/AIDS housing is increasingly important as the epidemic evolves and the costs of housing escalate.

4. **Access to housing, services, and benefits**. The paperwork required to access services and benefits, especially housing, is burdensome for people with HIV; and often consumers don't have the skills to advocate effectively through a bureaucracy.

Housing-Specific Issues

Members of the Steering Committee felt quite strongly that it is essential to develop and **maintain a comprehensive continuum** of housing and services for residents in San Diego County. Within that framework, two urgent gaps and two development issues were identified:

5. More **affordable permanent housing units** accessible to people living with HIV are needed. The housing continuum points people toward permanent independent living to the extent possible. However, the number of both facility-based and rental voucher units dedicated and/or accessible to persons living with HIV/AIDS and their families falls far

short of the need.

6. **Emergency housing**, both facility-based and hotel/motel vouchers, is needed to aid those who are homeless and in urgent need of shelter.

7. There is a need to employ a **variety of approaches** to increase the number of units available (including units with three or more bedrooms) in non-HIV-specific complexes and through mainstream affordable housing providers.

8. There exist a number of **barriers to housing development** in San Diego County including fees, complex financing and fund coordination, community concerns, and varying degrees of available resources for affordable and special needs housing development.

Service-Related Issues

In general, San Diego County has an excellent and comprehensive continuum of medical care, in terms of access to prescription drugs and social support services. However, the Steering Committee identified four key areas of concern related to maintaining the stability of residents in HIV/AIDS housing programs:

9. **There is not equal access to public transportation** in all parts of the county. Whereas there is some funding for transportation assistance, the size of the county and the uneven distribution of housing and support services within the county make transportation an ongoing concern for providers and consumers alike.

10. **Access to chemical dependency and mental health services** is also a problem. Coordination between these services and the HIV/AIDS continuum of care remains uneven and inadequate; at times they can even work at cross purposes.

11. It is essential that residents in HIV housing programs have the ability to **maintain case management relationships**. Case management is the crucial link between the resident and the array of services available through the various medical and support service systems. Currently, consumers may be cut off from or unable to access case management even while receiving housing assistance.

12. While not ranked as critical issues, **life/job skills and treatment adherence trainings** were identified as needed to help ensure that consumers are able to maintain their health and housing stability.

13. Increasing **child and respite care** for people living with HIV/AIDS with dependent children will enable parents to work and/or access services.

Increasing Funding and Support for HIV/AIDS Housing and Supportive Services Issues

14. There is a **need for effective education and outreach** to community members and leaders

to ensure the continued existence of community-based programs and to increase funding to meet the increasing local need.

15. **Prejudice** against the poor, people of color, immigrants, gays and lesbians, and those with histories of mental illness, chemical addiction, incarceration and/or homelessness, in addition to community concerns, are significant barriers to the siting and development of appropriate, affordable housing for people living with HIV and their families.

16. There is a **need for improving the coordination and collaboration** at every level in the systems of funding and delivery of medical, social, housing, HIV/AIDS, job training, mental health, and chemical dependency services.

Recommendations

The following recommendations are in summary form. The recommendations included in the *San Diego Countywide Strategic HIV/AIDS Housing Plan* provide a more detailed explanation of what is being recommended.

The thirty-one specific recommendations in this chapter are divided into four main categories: housing, service-related, system-wide, and increasing funding and support for HIV/AIDS housing and supportive services. The fourteen housing strategies are grouped within three overarching recommendations:

- Actively participate in community-wide planning for housing resource allocation
- Prioritize flexibility in increasing access to safe, affordable, and appropriate housing
- Create and maintain a full continuum of HIV/AIDS housing options

Housing Strategies

Actively participate in community-wide planning efforts for housing resource allocation

It is clear that the housing needs of all people living with HIV/AIDS in San Diego County cannot be met by the resources of the HIV/AIDS housing system alone, and that other low-income and affordable housing programs are necessary additional resources. Federal funds for housing and community development require coordinated planning and service delivery within participating jurisdictions. Homeless programs operate within HUD's Continuum of Care, and HOPWA-funded activities fall under the guidance of Consolidated Plans for several San Diego County jurisdictions. For these reasons, it is essential that the needs of people living with HIV/AIDS be addressed in these systems and planning efforts.

1. This plan and its recommendations form the framework for efforts to assure housing stability and housing options for San Diego County's HIV-infected residents and their families. As such, it belongs to the people of San Diego County, and it is the duty and

responsibility of community leaders to work for its full implementation.

2. People living with HIV/AIDS, AIDS housing and service providers, the cities in the county, HIV Health Services Planning Council, and members of the County HIV Housing Committee should work towards and participate in the development of regional affordable housing plans that include an emphasis on the needs of people living with HIV/AIDS and their families.

3. The San Diego County Department of Housing and Community Development (HCD), with community input and participation, should take the lead in ensuring that there is full participation by AIDS housing and service providers, and consumers in Consolidated Plan, Continuum of Care, and other housing and homeless advisory and planning activities in all participating jurisdictions in the county.

4. The HCD, with community input and participation, should review the *San Diego Countywide Strategic HIV/AIDS Housing Plan* annually to assure its relevance and accuracy. This review should also include funding decisions made and programs funded to assure that current programs adequately and appropriately address current needs.

Prioritize flexibility in increasing access to safe, affordable, and appropriate housing

Although there is an enormous unmet need for housing among people living with HIV/AIDS and their families, it is an unfortunate reality that San Diego County suffers from an extreme shortage of affordable housing of all kinds. Not only is the existing housing inventory limited, but also there is little hope for a substantial increase in units affordable to very-low-income households in the near future.

It is, therefore, incumbent upon planners, funders, developers, and providers to remain flexible and poised to take advantage of opportunities to increase access to safe, affordable, and appropriate housing as they arise. At the same time, the development of special-needs and affordable housing has become increasingly complex and competitive. It may take a developer two to three years to gain approval from all the relevant government bodies and assemble the financing necessary to both complete the construction and assure long-term affordability. Thus, consumers and advocates must both express urgent need and maintain patience throughout the development process.

5. After setting priorities for new unit creation in its annual Notice of Funding Availability (NOFA) for HOPWA funding, HCD should remain flexible as to the kind of activities that are allowable, e.g., AIDS-specific housing development, mixed-population housing development, AIDS set-asides in new or existing affordable/mainstream housing developments, master leasing, and other "nondevelopment" strategies. HCD staff should evaluate the short- and long-term cost-effectiveness and benefits of proposed strategies.

6. In advertising the availability of HOPWA funding for new unit creation and in conducting the subsequent proposers' conferences, the HCD should reach out to for-profit developers, housing authorities, and nonprofit affordable and mainstream housing developers to

encourage their participation. The HCD should also encourage these entities to increase their knowledge about the need for AIDS housing locally and the HCD's willingness to be flexible in pursuing a range of development strategies.

7. Balance development with rental assistance and other nondevelopment activities. As the HCD prioritizes the allocation of HOPWA and other resources towards the provision of housing for people living with HIV/AIDS and their families, every effort should be made to maintain a balance among the various housing strategies available and between short- and long-term housing needs.

Create and maintain a full continuum of HIV/AIDS housing options

It is the vision of the HCD and the Steering Committee and the mandate of the HIV Health Services Planning Council to assure the creation of a continuum of housing and services to meet the needs of people living with HIV/AIDS at all points in the disease spectrum. At the same time, the U.S. Department of Housing and Urban Development and San Diego County Department of Housing and Community Development desire the integration of HIV/AIDS housing with the homeless Continuum of Care and other affordable and special needs housing programs in the county. Towards those ends, the following recommendations articulate both a broad vision and some specific action steps. As appropriate, these actions should be taken in collaboration with the HIV Health Services Planning Council, Regional Continuum of Care Council, and the HIV Housing Committee.

8. Assure access to a range of housing options in San Diego County for people living with HIV/AIDS and their families. This includes emergency, transitional, permanent independent, and permanent supportive housing, as well as residential programs for persons with higher care needs.

9. Permanent independent housing is both the greatest single need in the county and the highest ranked housing preference among consumers.
   - To the extent possible, encourage dispersion of units where the greatest need is throughout the county. East County, central San Diego, and the South Bay have been identified as priority areas for the short term.
   - Steps should be taken immediately to increase access to units with three or more bedrooms to provide long-term housing for families impacted by HIV/AIDS.
   - Explore possible alternatives for providing some kind of "youth friendly" housing for 18- to 25-year-olds who are HIV-positive and homeless or at risk for HIV infection.

10. Maintain existing tenant-based rental assistance programs and explore potential changes that may enable more effective targeting of resources based on levels of income and need.

11. Review existing mechanisms for providing emergency housing and determine if changes are required to existing models of delivery, operating policies and procedures, or funding levels to better assist people living with HIV/AIDS and their families as they enter and later

pass through the AIDS housing continuum.

12. Strengthen the effectiveness of transitional housing programs through:
    - Staffing and procedural modifications that will enable them to better serve mono-lingual non-English-speaking consumers and those with mental health and chemical dependency issues; and
    - More closely linking transitional and permanent housing programs so that residents can be assured a smooth transition to permanent independent or supportive housing.

13. Maintain the existing Residential Care Facilities for the Chronically Ill (RCF-CI) in North County and encourage the development of a similar facility in central San Diego. Consumers, providers, advocates and planners all expressed a resounding endorsement of the ongoing need for the level of on-site care and supervision that the RCF-CI's provide. Further analysis is required in order to determine the optimal size and location for such a facility in San Diego, based on development and operational costs and siting issues.

14. Reach out to develop and maintain linkages with area skilled nursing and hospice facilities so that ready access for those who need those levels of care can be assured. Although the number of deaths from AIDS has decreased dramatically in recent years as a result of improvements in medical treatments and medication protocols, there remains an ongoing need for end-of-life care in San Diego County.

Service-Related Strategies

In order to assure the highest quality of life, health status and degree of housing stability possible, virtually all housing options for people living with HIV/AIDS and their families should include linkages to a continuum of community-based services. The HIV/AIDS continuum of care in San Diego County is well developed and offers access to the complete array of services needed. There remain, however, both significant unmet needs and opportunities for fine-tuning existing programs to better promote housing stability. As appropriate, these actions should be taken in collaboration with the HIV Health Services Planning Council.

15. The HCD and other funders should require that, prior to receiving funding for housing development and/or start-up of operations, providers of both facility-based and tenant-based HIV/AIDS housing programs demonstrate that services appropriate to the needs of potential residents will be provided on site, or that community-based services are accessible to residents and formal linkages for service delivery are in place.

16. Encourage the creation of a case management task force to review case management policies and guidelines with the goal of maximizing opportunities for consumer housing stability. With the current priorities for case management services, it is possible for a consumer receiving HOPWA subsidies or residing in a HOPWA-subsidized residence to become ineligible for AIDS case management services. Given that case management is the

primary point of access to the support services upon which a tenant's housing stability depends, consideration should be given to assure that at, a minimum, those receiving HOPWA housing assistance are guaranteed ready access to case management when they need it.

17. Increase access to services for people living with HIV/AIDS outside of the City of San Diego. People living with HIV/AIDS outside of the City of San Diego may have a difficult time accessing services due to the centralization of most services in central San Diego. Increased access to services is needed, through both ongoing transportation assistance and a commitment to service availability in outlying areas where feasible and appropriate. An outreach and subsequent educational effort is needed in the county's smaller communities to connect people living with HIV/AIDS to the services that are available to them. Consumers may also need training and ongoing support to increase their effectiveness as self-advocates.

18. Increase access to chemical dependency and mental health services, particularly for those on waiting lists for, or entering, HIV/AIDS housing programs. Consumers and providers alike indicated an unmet need in affordable and appropriate chemical dependency and mental health services. Coordination with the HIV Health Services Planning Council and the chemical dependency and mental health systems will be required and might be best addressed through existing task forces or collaborative efforts within city, county, and state government.

19. Increase access to life skills, job skills, and treatment adherence trainings. For many people living with HIV/AIDS, life skills, job training, and treatment adherence education is necessary to help ensure their ability to maintain their current health and housing stability.

20. Increase access to childcare and respite care for people living with HIV/AIDS with dependent children. Medical regimens, access to appropriate support services, and navigating the various benefit systems require that custodial parents be able to leave their dependent children in appropriate childcare settings for several hours or days at a time. Financial assistance and coordination of childcare resources may be necessary to assure appropriate physical and mental health treatment and compliance for both parent and child. Coordination with the HIV Health Services Planning Council and other local and state programs for child support and services is encouraged.

System-Wide Strategies

The system developed for providing housing and rental subsidies for people living with HIV/AIDS and their families in San Diego County has grown substantially over the past ten years as opportunities for expanding resources appeared in response to the evolving and increasing housing needs of consumers. The primary obstacle facing the system is the huge shortfall in resources when faced with the enormous need for affordable and appropriate housing. Many consumers are daunted by the complexities of the system and the nuances of program requirements. They frequently cite their own and providers' insufficient knowledge of

the AIDS housing system as one of their greatest barriers to finding and securing housing. As the efficacy of medical treatment and medication protocols has increased in recent years, AIDS housing providers' biggest challenge is not managing residents' medical needs; rather, it is addressing their behavioral health issues. Community concerns, siting, and permit issues are real barriers faced by special needs housing developers as they attempt to respond to consumer need and preference by creating housing and support service options geographically dispersed throughout the county. As appropriate, these actions should be taken in collaboration with the HIV Health Services Planning Council, Regional Continuum of Care Council, and the HIV Housing Committee.

21. Encourage and support continued and increased consumer involvement in the HIV/AIDS housing planning and decision-making process. Consumer input is vital both in determining the range and extent of need and in developing housing and support service options that are appropriate to and preferred by potential tenants.

22. Encourage housing developers in San Diego County to view themselves as "AIDS housing developers" and aggressively pursue options for:
    - Increasing access to safe, affordable and appropriate housing through set asides and other "nondevelopment" strategies; and
    - Developing new units of housing consistent with the goals of this Plan and priorities established on an annual basis by the HCD.

23. Encourage government and conventional lenders to modify and frame loan policies to encourage special needs affordable housing development.

24. Address siting and development barriers through both community education efforts and nondevelopment strategies. It is not just the difficulty in securing financing that mires the development of special needs housing projects; there are a number of barriers that can be affected by county and city governments, including development fees, permitting and siting requirements, and varying degrees of community commitment to affordable and special needs housing development.

25. Assure the quality of housing and related services provided to people living with HIV/AIDS and their families. Housing development and operation are complex activities requiring a broad range of skill and knowledge. Managing nonprofit organizations, complying with government contract requirements, and maintaining housing and service quality are equally challenging.

26. Examine the effectiveness of the current information and referral services and develop creative methods for further consumer and provider education. Consumers and providers alike indicated that lack of knowledge and difficulties associated with application and referral processes were barriers to housing in San Diego County.

27. AIDS housing providers and advocates should expand and strengthen existing linkages to AIDS support, mental health service, and chemical dependency treatment systems to

ensure access to these systems for eligible consumers.

Strategies for Increasing Funding and Support for HIV/AIDS Housing and Supportive Services

The majority of people contacted through the process of assessing the need for HIV/AIDS housing in San Diego County identified "increasing funding and support for HIV/AIDS housing and supportive services" as a key strategy for successfully housing people living with HIV/AIDS. In this era of fierce competition for limited funding, it is incumbent upon consumers, community leaders and interested parties of all kinds to become knowledgeable about HIV/AIDS issues in San Diego County and to help ensure the viability and support of community-based efforts to meet the needs of people living with HIV/AIDS.

28. Implement a community-wide educational program that provides valuable information about the epidemic, its trends, and the services available to people living with HIV/AIDS.

29. Encourage community members and leaders throughout San Diego County to embrace this Plan and take steps to engage others at appropriate levels of authority in city, county, state and federal government to assist in implementing its recommendations.

30. Encourage the increase of public and private funding for the range of housing and support service programs that people living with HIV/AIDS in San Diego County can access. Local and national coalitions exist to coordinate messages and advocacy strategies.

31. Work towards the implementation of rental programs and landlord-tenant provisions that are friendly to people living with HIV/AIDS. As the housing market continues to favor landlords in San Diego County, large increases in rent, large security deposits and rent down-payments, and increasingly stringent income requirements have become commonplace, squeezing low-income renters out of the housing market. It is imperative that the HIV/AIDS community, together with other groups representing low-income and similarly disenfranchised communities, encourage the development of tenant-friendly rental programs and flexible landlord-tenant provisions that will provide increased affordable housing opportunities for persons living with HIV/AIDS. The HCD, OAC, County HIV Housing Committee, HIV Health Services Planning Council, HIV/AIDS housing and service providers, and consumers should work for the following*:*

    - Development and implementation of a damage deposit and rent guarantee program to provide a bail-out to landlords if a tenant defaults on paying rent.

Action Plan for HOPWA Cycle VIII

The following recommendations were developed based on data from the needs assessment process, including consumer, provider, and case manager surveys; Steering Committee and

public meetings; one-on-one housing and service provider interviews; and consumer focus groups.

At the June 1999 meeting of the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee, recommendations were reviewed and the following recommendations were selected to be the first "action" steps. Given the dynamic nature of HIV disease and the uncertainty of future federal funding, the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs must be revisited regularly. Therefore, Action Plans will be developed on an annual basis.

Housing-Related Strategies

Recommendation:

Prioritize flexibility in funding HIV/AIDS housing activities. After setting priorities for new unit creation in its annual Request for Proposals for HOPWA funding, the San Diego County Department of Housing and Community Development (HCD) should remain flexible as to the kind of activities that are allowable, e.g., AIDS-specific housing development, mixed-population housing development, set-asides in new or existing affordable/mainstream housing developments, master leasing, and other "nondevelopment' strategies.

Action Steps:

- **HCD staff should evaluate the short- and long-term cost-effectiveness and benefits of proposed strategies.**
- **Incorporate the outcomes of this planning process into the development of priorities for HOPWA funding.**

Recommendation:

Assure the creation of a continuum of housing and services to meet the needs of people living with HIV/AIDS at all points in the disease spectrum. This goal is the vision of the HCD and the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee and the mandate of the HIV Health Services Planning Council.

Action Step:

- **Develop and publicly present an official "continuum of HIV/AIDS housing," including definitions of each type of housing. Emphasize the importance of housing stability to each person living with HIV/AIDS, especially in his/her ability to access services and medical care.**

Recommendation:

Increase permanent independent housing. It is both the greatest single need in the county and the highest ranked housing preference among consumers.

Action Steps:

- **Ensure the creation of up to 30 permanent independent housing units.**

Recommendation:

Maintain existing tenant-based rental assistance programs and explore potential changes that may enable more effective targeting of resources based on levels of income and need.

Action Steps:

- **Explore the possibility of requesting a shallow rent subsidy waiver from HUD for long-term HOPWA rental assistance.**
- **Coordinate potential HOPWA shallow rent subsidy with existing programs, including Partial Assistance Rental Subsidy (PARS).**
- **Maintain homelessness prevention as the primary focus of shallow rent subsidies.**
- **Evaluate the impacts of establishing higher income ceilings, the targeting of shallow subsidies to those with incomes between 50 percent and 80 percent of area median income, and allowing for different levels of assistance as income fluctuates or to accommodate rent increases.**
- **Consider prioritizing deep subsidies for those at the lowest income levels and for families needing units with three or more bedrooms.**

Recommendation:

Maintain the existing Residential Care Facilities for the Chronically Ill (RCF-CI) in North County and encourage the development of a similar facility in central San Diego. Consumers, providers, advocates and planners all expressed a resounding endorsement of the ongoing need for the level of on-site care and supervision that the RCF-CI's provide. Further analysis is required in order to determine the optimal size and location for such a facility in San Diego, based on development and operational costs and siting issues.

Action Step:

- **Assure adequate funding for the existing Residential Care Facilities for the Chronically Ill (RCF-CI) in North County and encourage the development of a similar facility in central San Diego.**

System-Wide Strategies

Recommendation:

AIDS housing providers and advocates should expand and strengthen existing linkages to AIDS support, mental health service and chemical dependency treatment systems to ensure access to these systems for eligible consumers.

Action Steps:

- **Establish and/or improve formal and informal linkages, with the support of the HCD and the San Diego County Office of AIDS Coordination (OAC), to the mental health and chemical dependency treatment systems, building upon existing relationships, and jointly advocating at the state level for more funding and targeted programs.**
- **Establish quarterly meetings of the executive officers of the County HIV Housing Committee, HIV Health Services Planning Council, and the staffs of the HCD and OAC. These meetings should focus on improving linkages between housing programs and other supportive services, including case management, mental health, and chemical dependency services, and establishing standards of care.**
- **Coordination between the HOPWA and Ryan White CARE Act planning and funding bodies should be improved in order to help assure optimal leveraging of resources and non-duplication of services.**
- **Cross training opportunities should be established so that front-line workers in the HIV/AIDS housing and support, mental health services and chemical dependency treatment systems can better respond to the range of issues that multiply diagnosed people living with HIV/AIDS face, and understand the capabilities and limitations of each system to respond.**

Strategies for Increasing Funding and Support for HIV/AIDS Housing and Supportive Services

Recommendation:

Work towards the implementation of rental programs and landlord-tenant provisions that are friendly to people living with HIV/AIDS. As the housing market continues to favor landlords in San Diego County, large increases in rent, large security deposits and rent down-payments, and increasingly stringent income requirements have become commonplace, squeezing low-income renters out of the housing market. It is imperative that the HIV/AIDS community, together with other groups representing low-income and similarly disenfranchised communities, advocate for tenant-friendly rental programs and flexible landlord-tenant provisions that will provide increased affordable housing opportunities for persons living with HIV/AIDS.

Action Steps:

- **The HCD, OAC, County HIV Housing Committee, HIV Health Services Planning Council, HIV/AIDS housing and service providers, and consumers should work for the following***:*
  - **Development and implementation of a damage deposit and rent guarantee program to provide a bail-out to landlords if a tenant defaults on paying rent**.

Table of Contents

Introduction

The County of San Diego contracted with AIDS Housing of Washington, a Seattle-based nonprofit agency, to conduct a needs assessment and facilitate a planning process leading to the development of an HIV/AIDS housing plan. The needs assessment included: a review of relevant planning documents and epidemiological data; consumer focus groups; site visits to AIDS housing programs; a case manager survey; a survey of affordable housing and AIDS service organizations; and one-on-one interviews with key housing and service providers. In order to assess the housing needs and preferences of consumers, a survey was distributed throughout San Diego County to people living with HIV/AIDS who receive HOPWA assistance. A Steering Committee, consisting of consumers, providers, public agencies, and affordable housing providers, assisted in the development of the consumer surveys and distribution strategies, monitored the needs assessment process, and assisted in interpreting its findings.

Background

The availability of safe, appropriate housing options has been a concern of advocates, service providers, and people living with HIV/AIDS in San Diego County throughout the epidemic. In recent years more individuals are indicating a need for on going or intermittent financial assistance to secure or maintain adequate housing.

The County of San Diego receives Housing Opportunities for Persons with AIDS (HOPWA) funding directly from the U.S. Department of Housing and Urban Development (HUD). The HOPWA program provides grant funds to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of low-income people living with HIV/AIDS and their families. The County of San Diego Department of Housing and Community Development retained AIDS Housing of Washington to provide leadership and consultation in a community-based needs assessment and planning effort.

The Context of AIDS Housing

This is a challenging time to be engaged in planning housing for people living with HIV/AIDS. Available federal funding, the changing demographics of the population of people living with HIV/AIDS, and advances in AIDS treatment protocols all impact planning for, and the provision of, AIDS housing and supportive services. Today, there is more uncertainty in the AIDS housing field than ever before, due to changes in the epidemic and the uncertainty of future federal funding. It is within this context of change that the *San Diego Countywide Strategic HIV/AIDS Housing Plan* was developed.

Funding

A 10 percent increase in HOPWA funds was included in the federal FY 1999 budget. However, the number of metropolitan areas and states that are eligible to receive formula allocations of those funds is increasing each year. In 1992 there were 27 eligible metropolitan statistical areas (EMSAs) and 11 states eligible to receive formula allocations of $42,935,000 in HOPWA funds. By 1995, funding had increased to $153.9 million, but grantees had increased to 66 (43 EMSAs and 23 states). In 1997, although grantees increased by 21 percent to 80, funding only increased by 15 percent, to $176.4 million. The amount received by each eligible metropolitan area or state is likely to plateau and may decline. Federal funding for homeless programs, HOPWA, and housing for the disabled and elderly remain under extreme budgetary pressure. Although another five to ten jurisdictions will become eligible for FY 2000 HOPWA formula awards, it is unlikely the program will see any significant budget increases.

Changing Needs of People Living with AIDS

People living with HIV/AIDS who are successfully taking anti-retroviral therapies are experiencing significantly improved health and changes in some of the markers used to measure levels of HIV in the blood. Many people living with HIV/AIDS are considering the possibility of re-employment and the impact of returning to work on disability and medical benefits. Nationally, AIDS death rates decreased for the first time in 1996 and continued to decline through 1999. The system must plan for the housing needs of people who are healthier and living longer, not just those who are severely ill and dying.

At the same time, however, recent studies suggest that as many as 50 percent of the individuals who are treated with protease inhibitors cannot tolerate the drugs, do not respond to them, or eventually decline after a period of positive response. We know that successful treatment with these drugs requires strict adherence to daily medical protocols. Stable housing is extremely important, if not essential, to such compliance. Homeless individuals are less likely to be prescribed protease inhibitors by their doctor because they are often unable to follow such protocols.

Planners and providers face challenging moral, political, and practical issues as an increasing proportion of the people accessing HIV/AIDS services and housing have histories of homelessness, mental illness, and chemical dependency. Demands on all of the systems serving people living with HIV/AIDS are increasing, but the resources necessary to meet identified needs may not be available in the future. Experience has shown that the provision of appropriate services for this multiply-diagnosed population is as critical to the residents' housing stability as the roof over their heads. However, it is very expensive to provide the level of support many of these individuals need in order to maintain their housing. Individuals who have had histories of chemical addiction, mental illness, and homelessness will need assistance to develop job skills, as well as ongoing support services, to be able to successfully enter the job market.

Planning Process

The community-based planning effort incorporated the input of interested community members including people living with HIV/AIDS, representatives of AIDS services and housing organizations, housing developers, members of local government agencies, and the general public. Members of the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee reviewed local housing and epidemiology data, distributed an HIV/AIDS housing consumer survey, determined target populations and arranged consumer focus groups, affirmed the critical issues and agreed on recommendations for inclusion in the plan. AHW provided data entry and analysis of the consumer, case manager, and provider survey data; conducted focus groups; facilitated key informant meetings; and wrote the plan.

Data reviewed in the development of the plan include information from the following sources:

- 1998 HIV/AIDS Needs Assessment, San Diego County
- 1999 Survey of People Living with HIV/AIDS: Preliminary Results, San Diego County Office of AIDS Coordination, May 1999
- California Association of Realtors
- Centers for Disease Control and Prevention
- City of San Diego
- Housing Authority of the County of San Diego
- Regional Task Force on the Homeless
- San Diego Association of Governments
- San Diego County Apartment Association
- San Diego County Department of Housing and Community Development
- San Diego County Health and Human Services Agency
- San Diego County Office of AIDS Coordination
- United States Bureau of the Census
- United States Department of Housing and Urban Development

In addition, local stakeholders participated in Steering Committee meetings, provider focus groups, key informant interviews, and HIV Housing Committee meetings. Site visits were made to Being Alive, St. Vincent de Paul, PACTO, Townspeople, Stepping Stone, Community Housing of North County, and Fraternity House. Focus groups were held with consumers, case managers, and with alcohol, drug abuse, and mental health stakeholders.

Strategic HIV/AIDS Housing Plan

The *San Diego Countywide Strategic HIV/AIDS Housing Plan* provides a framework for assessing and planning for the housing needs of people living with HIV/AIDS. It represents the culmination of a six month-long effort by a broad cross section of concerned citizens to determine the housing needs of people living with HIV/AIDS in San Diego County.

The Plan includes: an overview of housing and homelessness issues in the county; a summary of HIV/AIDS housing resources; the demographic profile of individuals who have been diagnosed

with AIDS; the results of the consumer, case management, and provider surveys; identification of critical issues; and recommendations.

Given the dynamic nature of HIV disease and the uncertainty of government funding in the future, the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs must be reassessed regularly. This Plan is intended to be built upon, revised, and expanded as the current objectives are met and new gaps and needs emerge.

Housing and Homelessness in San Diego County

Like many areas of the country experiencing high population growth, San Diego County is in the midst of an affordable housing crisis. The new unit construction is not keeping pace with population growth, resulting in increased demand for housing, particularly for low- and very low-income households with fixed or diminishing incomes. Rents have soared at alarming rates, and thousands of local residents have been faced with rent increases they can't afford.

This section of the plan provides an overview of the county's demographics and housing market and their impact on the housing needs of people living with HIV/AIDS. The information in this chapter is taken directly from reports, including the *Draft Regional Housing Needs Statement, San Diego Region (November 1998)*, provided by the San Diego Association of Governments.

The majority of people living with HIV/AIDS in San Diego County require some form of housing assistance to ensure their continued health and stability. Many people living with AIDS rely on Supplemental Security Income (SSI), currently $676 per month in San Diego County, as their sole source of income. While a small but growing percentage of people living with HIV/AIDS considers returning to work, the majority face formidable barriers to employment, including a lack of marketable skills, potential loss of benefits, and the specter of on going or recurring health problems.

Persons living with HIV/AIDS must compete for housing in a local housing market in which the cost of renting has become increasingly out of reach to virtually all households with very low incomes. The lack of affordable housing in San Diego County is not limited to urban neighborhoods of the City of San Diego. Indeed, the shortage of affordable housing is a countywide phenomenon.

The demand for housing subsidies has increased dramatically in response to recent large increases in local rental costs. At the same time, funding streams for subsidized housing have been flat funded or are declining, including both HUD's Supportive Housing Program and other federal and state housing programs. Furthermore, consumers with tenant-based Section 8 certificates and vouchers are experiencing increasing difficulty in finding units (within allowable rent ceilings) that meet HUD guidelines.

Some of the more important trends occurring in the local housing market are described in the following pages.

Demographic Profile

Population

In 1990, the U.S. Bureau of the Census reported that the population of San Diego County was 2,498,016. The estimated population in San Diego County for 1998 is 2,794,785, which represents a 12 percent increase in just eight years[1]. San Diego is the seventeenth largest metropolitan area in the nation.[2] ***Table 1*** shows the growth of some of San Diego County's cities between 1990 and 1998. Cities with population growth larger than 12 percent (the countywide growth level) between 1990 and 1998 are shaded.

Table 1
Total Population by Jurisdiction in San Diego County, and Percentage Increase between 1990 and 1998

Jurisdiction	1990 Population	1998 Population	Percentage Increase, 1990-1998	Percentage of Total County Population (1998)
Carlsbad	63,126	73,688	17%	3%
Chula Vista	135,163	162,047	20%	7%
Del Mar	4,860	5,257	8%	<1%
Coronado	26,540	26,777	1%	1%
El Cajon	88,693	94,490	7%	3%
Encinitas	55,386	58,915	6%	2%
Escondido	108,635	123,148	13%	4%
Imperial Beach	26,512	28,557	8%	1%
La Mesa	52,931	57,973	10%	2%
Lemon Grove	23,984	25,317	6%	1%
National City	54,249	54,400	<1%	2%
Oceanside	128,398	153,869	20%	6%
Poway	43,516	47,098	8%	2%
San Diego	1,110,549	1,224,848	10%	44%
San Marcos	38,974	50,827	30%	2%
Santee	52,902	56,538	7%	2%
Solana Beach	12,962	13,945	8%	1%
Vista	71,872	82,901	15%	3%
Unincorporated	398,764	454,190	14%	17%
Total	**2,498,016**	**2,794,785**	**12%**	**100.0%**

Source: 1990 Census and San Diego Association of Governments, *Draft Regional Housing Needs Statement, San Diego Region,* November 1998.

[1] San Diego Association of Governments, *Draft Regional Housing Needs Statement, San Diego Region,* November 1998.
[2] U.S. Census Bureau <www.census.gov>.

Based on 1998 estimates, 44 percent of the region's total population resides in the City of San Diego. The other incorporated cities in the County of San Diego comprise 40 percent of the population. The remaining 16 percent of the population live in unincorporated areas of the County. Six cities in San Diego County have experienced population increases of over 10 percent between 1990 and 1998, including San Marcos (30 percent); Chula Vista (20 percent); Oceanside (20 percent); Carlsbad (17 percent); Vista (15 percent); and Escondido (13 percent). Many of these communities, notably Carlsbad, Chula Vista, and San Marcos, are also projected to experience the highest population growth rates in the region over the next six years. Since 1990, a greater percentage of growth has been attributable to natural increase, with a decreasing proportion attributable to immigration.[3]

Race

The population of San Diego County was predominately Caucasian (61 percent) and Hispanic (23 percent) in 1997. Approximately 6 percent of the population is African American, and the remaining 9 percent is Asian and other racial backgrounds. ***Table 2*** demonstrates the diversity of some of the county's cities.

Table 2
Race by Selected Jurisdiction in San Diego Region
Number and Percentage*

Jurisdiction	Hispanic	Caucasion/ White	African American	Asian/Other Backgrounds
Carlsbad	16%	79%	1%	4%
Chula Vista	42%	44%	5%	10%
El Cajon	17%	76%	3%	4%
Escondido	29%	65%	1%	4%
La Mesa	12%	81%	3%	4%
National City	53%	22%	8%	17%
Oceanside	28%	57%	8%	7%
San Diego	23%	55%	9%	13%
San Marcos	33%	62%	2%	4%

Source: San Diego Association of Governments, *Draft Regional Housing Needs Statement, San Diego Region,* November 1998.

*Note: Percentages may add up to more than 100% due to rounding.

Income and Poverty

The U.S. Department of Housing and Urban Development 1998 median household income for San Diego County was $50,800. While over 50 percent of the county's households earned between $25,000 and $75,000 in 1997, 28 percent of households earned less than $25,000, and 14 percent earned less than $15,000.

[3] Ibid.

Among the county's communities outside of San Diego, four had significant percentages of residents earning less than $25,000. Based on HUD's guidelines for housing affordability, a household earning $25,000 per year could afford a maximum of $625 per month for rent and utilities. A household earning $15,000 per year could afford a maximum of $375 per month. ***Table 3*** indicates the communities that had high percentages of residents earning less than $25,000 in 1997.

Table 3
Percentage of Residents Earning Low Incomes, by Selected Jurisdiction in San Diego County, 1997*

Jurisdiction	Earning less than $10,000	Earning $10,000 to $14,999	Earning $15,000 to $24,999	Total Earning less than $25,000
El Cajon	11%	8%	18%	37%
Escondido	8%	8%	17%	33%
Imperial Beach	10%	8%	21%	39%
National City	14%	11%	20%	45%
San Diego County	**8%**	**6%**	**14%**	**28%**

Source: San Diego Association of Governments, *Draft Regional Housing Needs Statement, San Diego Region,* November 1998.

*Note: Percentages may add up to more than 100% due to rounding.

Income levels and earnings in San Diego County are below both state and national levels.[4] The county's per capita income has been decreasing since 1989, when it ranked eighth in the nation among comparative metropolitan areas. By 1994, it ranked fourteenth.

Income levels reported in the 1990 Census for San Diego County also showed strong regional variations in per capita income.[5] The per capita income for Del Mar was reported at $37,474, which represented an increase of 57 percent over 1985. By contrast, the per capita income for National City was reported at $8,658, which represented a decrease of 1 percent since 1985.

As in many other metropolitan areas, poverty among racial minorities in San Diego County is a significant problem. While the overall percentage of people living in poverty was approximately 13 percent in 1990, the percentage is much higher for most racial minorities: African Americans (21 percent), Hispanics (23 percent), and other races (26 percent). ***Table 4*** presents poverty status by race.

[4] Ibid.
[5] Ibid.

Table 4
Poverty Status by Race
San Diego County, 1989

Race	Population Above Poverty	Population Below Poverty	Percent of Population Below
Hispanic/Latino	372,664	110,061	22.8%
African American	111,027	29,972	21.3%
Native American	16,527	3,473	17.4%
Asian and Pacific Islander	168,722	25,482	13.1%
Caucasian	1,650,502	151,787	8.4%
Other Race	175,969	60,676	25.6%
County Total	**2,495,411**	**381,451**	**13.3%**

Source: 1990 Census

Housing Market

Like many areas of the country experiencing high population growth, the San Diego County region is in the midst of an affordable housing crisis. In the last five years, new unit construction has not kept pace with population growth, resulting in increased demand for housing, particularly for low- and very low-income households with fixed or diminishing incomes. Rents have soared at alarming rates, and thousands of local residents have been faced with increases they can no longer afford.

Housing Affordability

The number of people priced out of the homeownership market is steadily increasing. Consequently, there has been a noticeable shift in tenure trends, with more and more people remaining in the rental market, exacerbating the competition for scarce affordable housing units. At the same time, rising construction and land costs discourage the development of affordable housing. In fact, developers have been building more luxury apartment complexes, which now comprise a growing share of new housing starts.

Although, in theory, new construction should ease the demand for housing overall, it will be of little benefit to low- and moderate-income households, because of this shift toward higher-end housing. For new apartments built in the county since 1994, the average monthly rent is currently $1,061, which is over $300 higher than the average rent for all units combined. These units are affordable only to households who earn 80 percent or more of the area median income ($40,640).

The average monthly rent in San Diego County rose to $739 by the fall of 1998. This represents a 9.2 percent increase over 1997, and a 24 percent increase since 1994. In comparison, the

Consumer Price Increase for Urban Wage Earners and Clerical Workers has only grown 1 percent since 1997 and 9 percent since 1994.[6]

Table 5 shows the average apartment rent for one-bedroom apartments, by selected San Diego County city or neighborhood, in the fall of 1997, the fall of 1998, and the percentage increase from the fall of 1997 to the fall of 1998. Each of these jurisdictions has experienced an increase of $100 or more in average rent for a one-bedroom apartment from the fall of 1997 to the fall of 1998.

Table 5
Apartment Rents for One-bedroom Units in Selected Jurisdictions, Fall 1997, Fall 1998, and Percent Increase from Fall 1997

City/Area	Rent (Fall 1997)	Rent (Fall 1998)	Percent Increase from Fall 1997
Del Mar	$585	$934	60%
Central San Diego	$493	$696	41%
Linda Vista	$756	$972	29%
Encanto	$434	$562	29%
Logan Heights	$442	$562	27%
La Jolla	$623	$770	24%
Bonita	$605	$732	21%
Mission Village	$554	$657	19%
Sorrento Valley	$733	$834	14%
University City	$860	$976	13%

Source: San Diego County Apartment Association, Rental Owner Report, December 1998.

Vacancy Rates

Vacancy rates are a useful measure of the level of choice a consumer has in the rental market. High vacancy rates typically indicate that the demand for housing is low and the supply is more than adequate. Low vacancy rates, on the other hand, translate into high demand for a limited supply of housing. When vacancy rates become too low, rents will increase. In general, vacancy rates in the range of 5 to 6 percent are considered healthy for multi-family housing (apartments). For single-family housing (homes), healthy vacancy rates tend to be somewhat lower, closer to 2 or 3 percent.

Since 1994, vacancy rates throughout the region have decreased significantly.[7] In the fall of 1994, the overall vacancy rates for the City and County of San Diego were 6.7 percent and 7.6 percent respectively. By the fall of 1996, the vacancy rates for the City and County decreased to 3.9 percent and 4.2 percent respectively. In 1998, the vacancy rates for the City and County were reported at 1.8 percent and 1.7 percent respectively.

[6] San Diego County Apartment Association, Rental Owner Report, December 1998.
[7] Ibid.

Housing Problems

Many of the county's households experience one or more of the following housing problems:

- Overcrowding (9 percent of county households). Overcrowding, often a result of an expensive housing market, is prevalent in many communities in San Diego County, most notably National City (28 percent of households) and Imperial Beach (14 percent).
- Housing cost burdens, or paying more than 30 percent of household income on housing costs (41 percent of county households).
- Worst case households, or those earning less than 50 percent of area median income and paying over half of their income on rent, living in substandard housing, or both (75,000 in 1994).[8]

Table 6 demonstrates how much San Diego County renters can afford to pay without incurring a housing cost burden and compares that amount to the fair market rent (FMR), $510, for the cheapest apartments in the county, zero-bedroom units. Note that FMRs are reported at the county level only, without regard to regional market variations or market variations within a single jurisdiction. For these reasons, the actual affordability gaps for each of the income categories presented below are likely to be understated.

Table 6
Housing Affordability Gaps for Low Income Residents of San Diego County, 1999

Income Level	Income Range for Single Person (per month)	30% of Income (Cost Burden Level)	FMR for O-Bedroom Unit	Affordability Gap
SSI Level ($676)	$676	$203	$510	$307
0–30% of MFI*	$0–$905	$0–$271	$510	$239–$510
30–50% of MFI	$906–$1,532	$272–$459	$510	$51–$238
50–80% of MFI	$1,533–$2,450	$460–$735	$510	$0–$50

Sources: <www.huduser.org/data/asthse/fmr/fmr99/hud99ca.txt> and <www.ssa.gov/pubs/11001.html>.

*Note: MFI is an acronym for median family income. According to the U.S. Bureau of the Census, family includes the family householder and all other people in the living quarters who are related to the householder by birth, marriage, or adoption.

Affordable Housing Inventory[9]

The number of public housing units and Section 8 vouchers and certificates has remained more or less unchanged in San Diego County since January 1997. The number of project-based public housing units administered through the San Diego County Housing Authority is 121. An

[8] San Diego Association of Governments, *Draft Regional Housing Needs Statement, San Diego Region,* November 1998.
[9] The County of San Diego Department of Housing and Community Development tends a "Housing Resources Directory" annually. Contact the County directly or go to their web site: www.co.san-diego.ca.us/cnty/cntydepts/community/housing_community_development/hrd.html.

additional 197 units are available through the San Diego County Housing Authority's Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO) Program, which provides rental assistance to homeless people residing in privately-owned, rehabilitated SRO properties.[10] The San Diego County Housing Authority administers 5,732 tenant-based Section 8 certificates and 3,144 tenant-based Section 8 vouchers.[11]

In addition to the county's affordable housing opportunities, other jurisdictions within the county have affordable housing programs which are available to each jurisdiction's respective residents. For example, the City of San Diego provides Section 8 rental assistance to 9,000 households and public housing to 1,850 households. El Cajon (2,037 households), Chula Vista (1,991), Escondido (1,098), National City (1,044), and Oceanside (1,250) each provide Section 8 rental assistance to over 1,000 households annually.

Homelessness Profile

Overview

The extent of homelessness in San Diego County can only be estimated, given that the homeless by definition have no fixed address, which makes counting them very difficult. The Regional Task Force on the Homeless (RTFH) estimates that there are at least 15,000 persons throughout San Diego County who meet the HUD definition of homelessness. Resident farm workers and day laborers comprise more than half of this estimated range. These totals do not include undocumented persons who may be homeless.

Within San Diego's Central and Northern regions, there are an estimated 6,500 homeless people, many of whom live in Middletown. Approximately 6,000 homeless people live in North County Inland (many of whom are undocumented), 3,500 in North County Coastal, 1,000 in South Bay, 1,000 in East County, and 600 homeless people live in the beach communities.[12]

The RTFH cites the following common factors for homelessness in the San Diego area: an inability to pay high rent, residence was demolished or condemned, inability to remain in the former household, mental illness, illegal substance use, and poor health.

The numbers presented above do not account for the large and growing number of people who are not sleeping outside or residing in shelters, but who are at imminent risk of becoming homeless. Many of these individuals are living with friends and relatives on a temporary basis, or have exceedingly high housing costs.

The majority of the urban homeless in San Diego seek permanent employment and are considered transient because they follow opportunities for employment as day laborers. Approximately 20 percent are employed, at least on a part-time basis. Typically, this population

[10] Under the SRO program, HUD contracts with public housing authorities (PHAs) to enable the moderate rehabilitation that, when completed, will contain multiple single-room dwelling units. The PHAs make rental assistance payments to landlords on behalf of the homeless individuals who rent the rehabilitated units, covering the difference between a portion of the tenant's income (usually 30 percent) and the HUD-established FMR.
[11] HUD is currently encouraging that certificates be turned in for vouchers.
[12] Regional Task Force on the Homeless, *Regional Homeless Profile*, 1998.

is constantly moving through shelters, transitional housing, residential hotels, and friends' homes due to their extremely low incomes and because of the high cost of housing in San Diego. Over half have received their high school diploma, and approximately 20 percent have completed one or more years of college. Seventy-five percent of the urban homeless are single adults.[13]

Families and Children

Women, either as individuals or as head of households, represent 10 to 15 percent of the urban homeless population.

Within San Diego County, there are at least 2,100 urban homeless family members at any given time, two-thirds (1,400 to 1,500) of whom are children. This is the fastest growing segment of the homeless population, yet still represent less than a third of the urban homeless population. Single women who have fled abusive situations or have been abandoned by their spouses and/or boyfriends head most of these families.[14]

Youth

Young people are a growing segment of the homeless population in San Diego County. RTFH estimates that 800 young people are homeless on any given night.[15]

Veterans

There are approximately 2,000 homeless veterans in the San Diego region, or 40 percent of the urban adult homeless population.[16]

Chemically Dependent

According to various studies, approximately one-third of the adult homeless suffer from chronic alcoholism, and approximately 10 percent have chronic drug problems. The chemically dependent are frequently unable to access housing because they are unable to stay sober long enough to be eligible for residential services. As a result, this segment of the population has very limited opportunities for stability in their lives. Approximately half of the county's severely mentally ill homeless are believed to be abusing drugs and/or alcohol.[17]

Mentally Ill

Approximately one-third (1,700 persons) of San Diego's homeless adults and 10 percent (210 persons) of the homeless family members are mentally ill. The majority of the mentally ill reside in central San Diego.[18]

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[13] Regional Task Force on the Homeless, *Regional Homeless Profile*, 1998.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.

HIV and Homelessness

Based on reports by the National Commission on AIDS, approximately 15 percent of homeless persons in urban areas may be HIV-infected. In San Diego County, with an adult urban homeless population of 5,900 (this number excludes families and farm workers), it is estimated that about 900 urban homeless persons in the county may be HIV-infected.[19]

Housing Opportunities for Homeless Persons in San Diego

San Diego County's Regional Task Force on the Homeless has compiled an inventory of housing opportunities for the homeless. ***Table 7*** summarizes, by region, the distribution of housing units/beds for the homeless in the county, units that are set aside for targeted populations, and units set aside for clients with special needs.

[19] Ibid.

Table 7

Distribution, by Region, of Housing Units/Beds for Homeless Persons in San Diego County, Units Set Aside for Target Populations and for Clients with Special Needs

	East County	North County Coastal	North County Inland	San Diego	South Bay	Total
Housing Type						
Emergency Housing	23	59	48	205	–	**335**
Perm. Supp. Housing	–	53	26	28	–	**107**
Transitional Shelter	189	438	328	2,098	146	**3,199**
Total	**212**	**550**	**402**	**2,331**	**146**	**3,641**
Target Population						
Family with Children	101	155	109	345	125	**835**
Adult Men	36	173	45	892	13	**1,159**
Adult Men &/or Women	29	23	80	521	–	**653**
Adult Women	–	–	42	286	–	**328**
Homeless Youth	46	35	–	102	8	**191**
Women with Children	–	136	82	185	–	**403**
General Population	–	28	44	–	–	**72**
Total	**212**	**550**	**402**	**2,331**	**146**	**3,641**
Special Needs of Clients						
General Homeless	34	338	188	1,435	93	**2,088**
Chemical Dependency	162	96	126	465	13	**862**
Farm &/or Day Laborers	–	–	–	–	–	**–**
Victims of Dom. Viol.	–	71	–	135	40	**246**
Severe mental illness	16	17	20	104	–	**157**
SMI & Chemical Dependency	–	–	–	108	–	**108**
HIV/AIDS	–	28	14	52	–	**94**
Veterans	–	–	54	–	–	**54**
HIV/AIDS & Veterans	–	–	–	32	–	**32**
Total	**212**	**550**	**402**	**2,331**	**146**	**3,641**

Source: Regional Task Force on the Homeless, *Homeless Services Profile*, January 1999.

Summary

The population of San Diego County increased greatly between 1990 and 1998—9 percent overall, and over 20 percent in Chula Vista, Oceanside, and San Marcos. Over 13 percent of the region's residents are living in poverty; and people of color, especially African Americans and Hispanics, are more likely to live in poverty than Caucasians.

Rents are rising throughout the county at an alarming rate, and vacancy rates have plummeted. The result is that most low-income residents cannot afford adequate housing. Many households are experiencing housing problems, including overcrowding (9 percent of county households) and housing cost burdens (41 percent). And while public housing and Section 8 housing is available throughout San Diego County, waiting lists are long; and there is a clear need for more affordable, permanent housing.

The homeless population in the county is large, and is likely to grow as more low-income residents experience housing problems. Individuals living with HIV/AIDS are impacted by the same housing market, lack of affordable housing, and gaps in assistance to homeless persons as are other residents. The housing problems of low-income and homeless persons are compounded when they are also living with HIV/AIDS—fluctuations in their health affect their ability to work, pay rent, search for housing, and pay medical bills, among other problems—underscoring the need for more affordable housing units in San Diego County dedicated or accessible to people living with HIV/AIDS.

HIV/AIDS in San Diego County

An analysis of the housing needs of people living with HIV/AIDS is not complete without an understanding of the demographic profile of infected individuals. Only AIDS, not HIV infection, is reportable in San Diego County.

As of August 31, 1999:

- 10,029 people had been diagnosed with AIDS;
- 4,219 people are estimated to be living with AIDS; and
- Between 10,000 and 14,000 people are estimated to be living with HIV, including approximately 8,000 who are HIV positive and not diagnosed with AIDS.

Currently, an increasing proportion of San Diego County's AIDS cases are among African-Americans, Hispanics, heterosexuals, and women.

This chapter is intended to provide an overview of the demographic profile of the population living with HIV/AIDS in San Diego County. This information may be used as a foundation for decision-making and the prioritization of AIDS housing resources.

AIDS case reporting by county or diagnosis is required by law, pursuant to California Code of Regulations, Health and Safety Statutes, Title 17, Section 2500. Reports come from physicians, health providers, hospitals, and clinics via confidential morbidity reports. HIV infection, without an AIDS diagnosis, is not reportable anywhere in the State of California. Unless otherwise referenced, the information in this chapter is taken directly from reports provided by the County of San Diego Health and Human Services Agency, AIDS and Community Epidemiology, AIDS Epidemiology Unit.

Overview

The number of cumulative AIDS cases (through December 1998) placed San Diego sixteenth among all cities in the United States, giving the region a higher number of AIDS cases than those reported from 41 states, Puerto Rico, and the District of Columbia. San Diego's 9,643 cumulative AIDS cases reported as of December 1998 represented nearly one-fourth of the AIDS cases reported in California.[20] Sixty-five percent of cumulative AIDS cases reported through August 31, 1999 had been reported in the Central San Diego region of the county.[21]

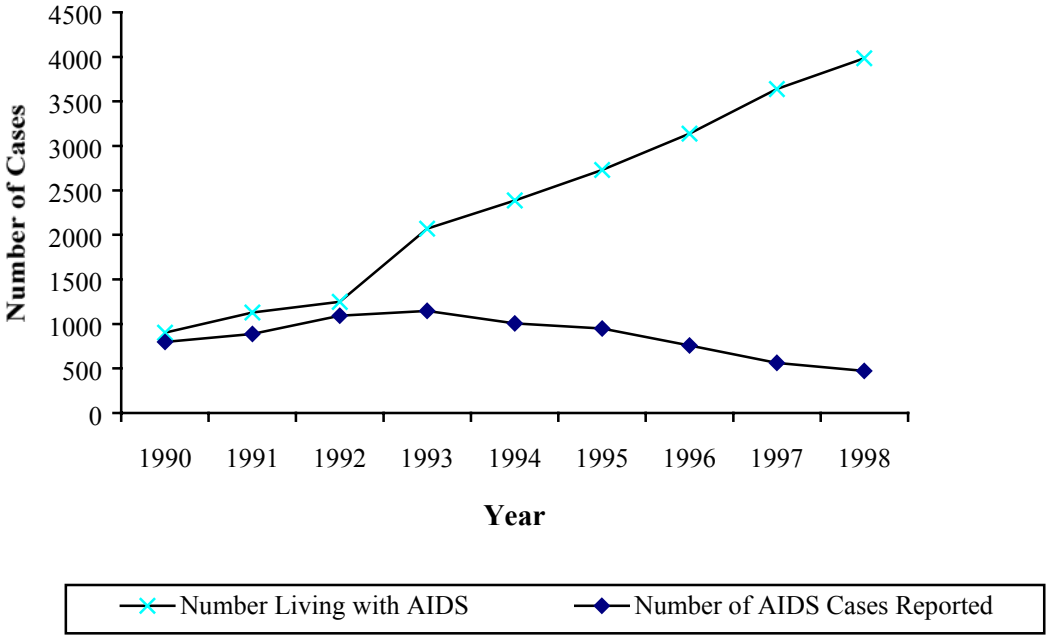
[20] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year-end Edition*, December 1998.
[21] San Diego County Health and Human Services Agency Office of AIDS Coordination.

Profile of Reported AIDS Cases

The San Diego County Health and Human Services Agency estimates that there have been 10,029 cumulative AIDS cases reported in San Diego County between 1981 and August 31, 1999. The number of new AIDS cases reported has been declining steadily since 1993, when 1,146 new AIDS cases were diagnosed. In 1998 the number of new cases diagnosed was 474.[22] However, as ***Figure 1*** shows, the number of AIDS cases diagnosed has been declining in recent years and the number of people living with AIDS has been increasing. This shows that despite the decrease in the number of people diagnosed with AIDS, not to mention the decreasing death rates and decreasing numbers of HIV positive people that progress to full-blown AIDS, those that have been diagnosed are now more likely to live longer.

Figure 1

Diagnosed AIDS Cases, 1990 through 1998,
People Living with AIDS, 1990 through 1998



Gender

The incidence of AIDS and HIV among women is increasing in both the national and San Diego County totals. The United States has a cumulative AIDS case gender ratio of 84 percent men to 16 percent women, although in cases reported in 1998 the ratio shifted to 77 percent to 23 percent. Furthermore, in the 31 states that report HIV infection (California is not one of them), women accounted for 32 percent of all new HIV infections during the period July 1997 to June 1998.[23]

[22] Incomplete reporting; cases diagnosed in 1998 will continue to be reported throughout 1999 and into 2000.
[23] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year-end Edition*, December 1998.

In San Diego County, cumulative reported AIDS cases have been male dominated (93 percent), yet new cases reported for 1997 and 1998 show that cases reported among women accounted for 10 percent of all cases.

The 1998 AIDS case rate nationally is 34 per 100,000 men, and 10 per 100,000 women; in San Diego County, the case rate is 36 per 100,000 men and 4 per 100,000 women.[24]

Race

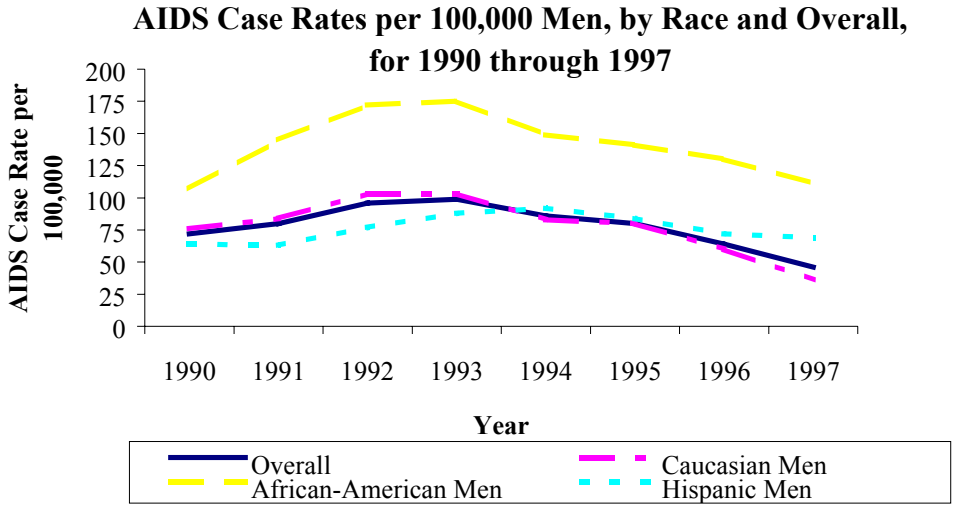
Caucasians account for 68 percent of the county's cumulative AIDS cases, while Hispanics account for 19 percent, African Americans 12 percent, Asian/other race 3 percent.[25]

The percentage of AIDS cases reported annually among Caucasians in San Diego County is on the decline, while AIDS cases reported among Hispanics and African Americans is on the rise. Among recent AIDS cases (1997 and 1998), Caucasians account for 52 percent of the county's reported AIDS cases, Hispanics 29 percent, African Americans 17 percent, and Asian/other race 3 percent.

While only 6 percent of the county's total population are African American, 12 percent of cumulative AIDS cases and 17 percent of recent cases have been African American. In addition, Hispanics account for 29 percent of recent AIDS cases yet only 24 percent of the county's total population.

Figure 2 demonstrates the increasing number of AIDS cases among San Diego County's men of color by comparing AIDS case rates per 100,000 men for each racial group from 1990 through 1997.

Figure 2



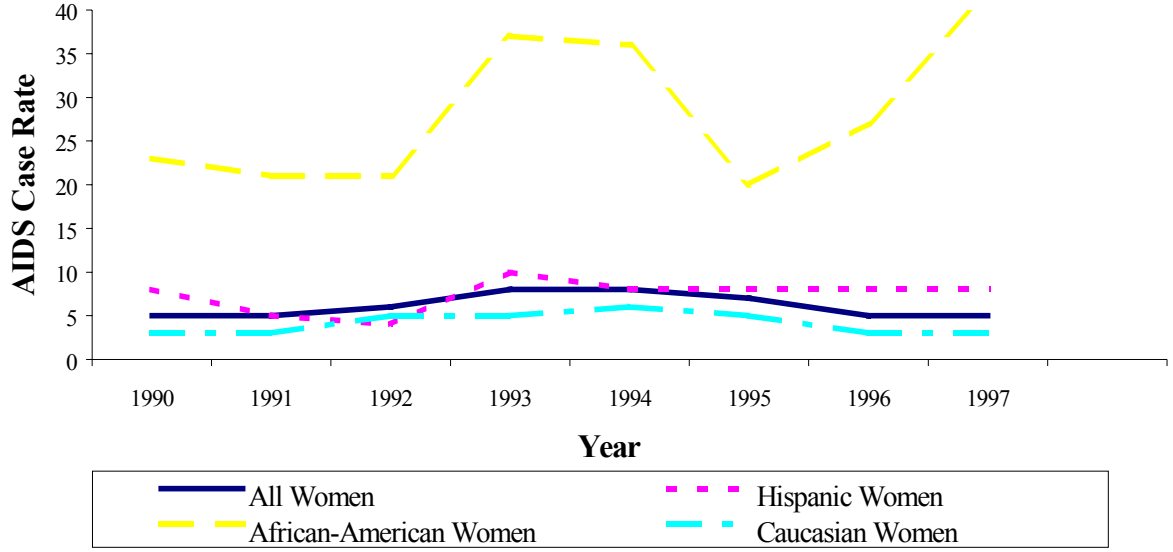
[24] Incomplete reporting; cases diagnosed in 1998 will continue to be reported throughout 1999 and into 2000.

[25] Available population data combines Asian/Pacific Islander and Native American racial/ethnic groups into one category: Asian/Other.

Figure 3 demonstrates that AIDS case rates in the county among Hispanic and especially African American women have generally been higher than that of Caucasian women and the overall adult/adolescent female case rate. AIDS case rates for African American women continue to rise, even as male AIDS case rates decline and Caucasian and Hispanic women AIDS case rates plateau.

Figure 3

AIDS Case Rates Among Women, by Race and Overall, for 1990 through 1997



Age

Ninety percent of cumulative and recent (1997 and 1998) AIDS cases were reported among people 20-49 years old, with almost half (47 percent) of the total cases falling in the 30-39 age range. ***Table 8*** presents cumulative and recently reported AIDS cases in San Diego County by age.

Table 8
Cumulative and Recent AIDS Cases, by Age*

Age	Cumulative AIDS Cases (through 8/31/99)		Recent AIDS Cases (Dx: 1997–1998)	
	Number	Percent	Number	Percent
Under 19	86	1%	7	<1%
20-29	1,767	18%	147	15%
30-39	4,699	47%	499	49%
40-49	2,502	25%	275	26%
50 and older	975	10%	110	10%
Total	**10,029**	**100%**	**1,038**	**100%**

*Note: Percentages may add up to more than 100% due to rounding.

Transmission Categories

The majority of new AIDS diagnoses are seen among men who have sex with men, although recent data show increasing proportions among injection drug users and heterosexuals, which is consistent with national trends. Seventy-seven percent of cumulative reported AIDS cases have been attributed to men having sex with men (MSM), yet that number has declined to 70 percent of recent cases (1997 and 1998). Meanwhile, among recent AIDS cases, more people have attributed their HIV infection to injection drug use (12 percent) and heterosexual sex (8 percent) than cumulative AIDS cases (8 percent and 4 percent, respectively).

Table 9 presents cumulative and recent AIDS cases for San Diego County by transmission category.

Table 9
Cumulative and Recent AIDS Cases, by Transmission Category*

Transmission Category	Cumulative AIDS Cases (through 8/31/99)		Recent AIDS Cases (Dx: 1997–1998)	
	Number	Percent	Number	Percent
Adults				
Men having sex with men (MSM)	7,650	77%	723	70%
MSM/IDU	873	9%	89	9%
Injection drug users (IDU)	819	8%	125	12%
Hemophilia	57	1%	3	<1%
Heterosexual contact	387	4%	80	8%
Transfusion/tissue	150	2%	5	<1%
Risk not reported or identified	41	<1%	10	1%
Children 13 and under				
Hemophilia	3	6%	0	0%
Mother at risk/perinatal transmission	42	81%	3	100%
Transfusion/tissue	7	13%	0	0%
Risk not reported or identified	0	0%	0	0%
Total	**10,029**	**100%**	**1,038**	**100%**

*Note: Percentages may add up to more than 100% due to rounding.

Location of Reporting

The majority of AIDS cases reported in San Diego County are reported in Central San Diego, which includes the City of San Diego. Cumulatively, 65 percent of cases have been reported in Central San Diego, while among recent cases (January 1, 1997 through August 31, 1999), 59 percent have been reported in Central San Diego. The South Bay area has seen an increase in its percentage of the county's reported AIDS cases: South Bay accounts for only 8 percent of cumulative AIDS cases yet 13 percent of recent AIDS cases. ***Table 10*** presents the cumulative and recent number of cases and the percent of the county's total cases reported from the five regions of the county.

Table 10
Cumulative and Recent AIDS Cases, by Location of Reporting*

Location	Cumulative AIDS Cases (through 8/31/99)		Recent AIDS Cases (1/1/1997 through 8/31/99)	
	Number	Percent	Number	Percent
Central San Diego	6,519	65%	737	59%
East County	741	7%	97	8%
North County	1,144	11%	148	12%
South Bay	755	8%	160	13%
South/Southeast San Diego	870	9%	107	9%
Total	**10,029**	**100%**	**1,249**	**100%**

*Note: Percentages may add up to more than 100% due to rounding.

Some discrepancies can be found in the demographic breakdown of AIDS cases reported in the five regions of the county. The following is a brief comparison of county wide and regional epidemiology, for cumulative AIDS cases (through 8/31/99) and recent AIDS cases (1/97 through 8/31/99):

- Central San Diego reports the majority of the county's cases, and, therefore, has similar demographics to the county as a whole. However, 81 percent of the region's cumulative AIDS cases have been attributed to men having sex with men (MSM), compared to 76 percent for the entire county.
- Southeast San Diego reports 19 percent of its recent (Dx: 1/97 through 8/99) AIDS cases have been attributed to injection drug use (IDU) and 12 percent have been attributed to MSM/IDU, compared to 12 percent and 8 percent, respectively, for the entire county.
- Ten percent of Southeast San Diego's recent AIDS cases have been attributed to heterosexual activity, compared to 7 percent for the county.
- Southeast San Diego reports lower percentages of AIDS cases, both recently and cumulatively, among Caucasians and males, and more AIDS cases, both recently and cumulatively, among African Americans, Hispanics, Asian/Pacific Islanders, and women, than does the entire county.
- North County reports higher percentages of AIDS cases among Caucasians (64 percent) and people older than 50 (14 percent) than the entire county (53 percent and 11 percent, respectively).
- East County reports higher percentages of AIDS cases among Caucasians cumulatively (73 percent) and recently (59 percent) than the entire county (68 percent and 53 percent, respectively).

- South Bay reports higher percentages of AIDS cases among heterosexuals cumulatively (8 percent) and recently (12 percent) than the entire county (4 percent and 7 percent, respectively).
- South Bay reports lower percentages of AIDS cases both cumulatively and recently among Caucasians and men, and much higher percentages among Hispanics and women.

People Living with AIDS

As of August 31, 1999, an estimated 4,219 people were living with AIDS in San Diego County. ***Table 11*** presents a basic demographic profile of those known to be living with AIDS in the county as of August 31, 1999.

Table 11
Demographic Profile of Individuals Known to be Living with AIDS in San Diego County (as of August 31, 1999)*

Demographic Category	Number	Percent
Race		
Caucasian	2,595	62%
Latino/Hispanic	937	22%
African American	571	14%
Asian/Pacific Islander	95	2%
Native American/Alaska Native	21	1%
Gender		
Male	3,859	91%
Female	360	9%
Age		
Under 19	41	1%
20–29	809	19%
30–39	2,010	48%
40–49	1,054	25%
50 and older	305	7%
Adult Transmission Category		
Men who have sex with men (MSM)	3,126	74%
Injection drug users (IDU)	389	9%
MSM/IDU	369	9%
Heterosexual contact	230	5%
Transfusion	35	1%
Hemophilia/coagulation disorder	20	<1%
Risk not reported or identified	64	5%

*Note: Percentages may add up to more than 100% due to rounding.

Estimated Number of HIV Cases

In August 1998, the County of San Diego Health and Human Services Agency estimated approximately 9,762 to 13,510 (midpoint = 11,636) people, or one in every 240 residents in San Diego County, were infected with HIV, including people living with AIDS.[26] Concurrently, the California State Office of AIDS calculated between 8,900 and 12,300 HIV infections in San Diego County.

Table 12 provides estimated HIV prevalence by gender, race, and transmission category for the estimated 8,109 people living with HIV (not AIDS) in San Diego County as of August 1998. This estimate was based on the midpoint noted above (11,636), minus the number of people living with AIDS as of the end of 1997.

Table 12

Estimated HIV Prevalence, by Gender, Race, and Transmission Category (as of August 1998)*

Demographic Category	Number	Percent
Race		
Caucasian	4,111	51%
Latino/Hispanic	2,381	29%
African American	1,341	17%
Asian/Pacific Islander	246	3%
Native American/Alaska Native	30	<1%
Gender		
Male	7,334	90%
Female	775	10%
Adult Transmission Category		
Men who have sex with men (MSM)	5,727	71%
Injection drug users (IDU)	1,021	13%
MSM/IDU	626	8%
Heterosexual contact	430	5%
Receipt of blood, components, or tissues	33	<1%
Hemophilia/coagulation disorder	10	<1%
Risk not reported or identified	221	3%
Total	**8,109**	**100%**

*Note: Percentages may add up to more than 100% due to rounding.

[26] Estimates were based on the Center for Disease Control report, *Simple Methods for Estimating HIV Prevalence*.

Homelessness and HIV/AIDS

Based on studies on HIV and homelessness, it is estimated that at least 15 percent of all homeless people in San Diego County are HIV-positive. The County of San Diego Health and Human Services Agency, Office of AIDS Coordination estimates that 15 percent or more of the urban homeless (approximately 1,125 persons) are HIV-infected.

Homeless persons with HIV usually have an urgent need for housing and supportive services that can help them avoid the cycle of homelessness. Supportive services most frequently needed include: chemical dependency recovery, mental health services, and assistance with activities of daily living (ADLs). Homeless persons with HIV are at much higher risk of acquiring tuberculosis compared to the general homeless population, and, therefore, constitute a greater public health concern.

Table 13 illustrates the demographics of the 102 homeless respondents to the 1998 HIV/AIDS Needs Assessment for San Diego County.

Table 13

Demographic Profile of 1998 HIV/AIDS Needs Assessment Respondents who Indicated They Were Homeless in San Diego County (n=102)*

Demographic Category	Percent
Race	
African American	38%
Latino/Hispanic	24%
Caucasian	21%
Asian/Pacific Islander	3%
Native American/Alaska Native	1%
Gender	
Male	87%
Female	9%
Transgender	2%
HIV Health Status	
AIDS-diagnosed	37%
HIV-positive, with symptoms	33%
HIV-positive, without symptoms	25%
Sexual Orientation	
Gay/Lesbian	50%
Heterosexual	32%
Bisexual	14%
Residence	
Central San Diego	46%
Southeast San Diego	7%
North County	4%
South Bay	3%
East County	2%
No response	38%
Other Demographics	
Used illegal drugs in last 6 months	40%
Recovery from chemical dependency	31%
Ex-inmate	25%
Chronic mental illness	23%
Injection drug user—within last 6 months	14%
Tuberculosis	5%

Source: 1998 HIV/AIDS Needs Assessment, San Diego County, San Diego Office of AIDS Coordination, November 1998.

*Note: Percentages may add up to more than 100% due to rounding.

Summary

As of August 31, 1999, 10,029 cases of AIDS had been diagnosed in San Diego County. Of these, 4,219 people were believed to be living with AIDS. An additional estimated 8,000 people are HIV positive yet do not have AIDS. An increasing proportion of reported AIDS cases are among Hispanics, African Americans, women, injection drug users, and those who contract the disease through heterosexual contact. Meanwhile, reported AIDS cases among men who have sex with men and Caucasians are declining.

In San Diego County, cumulative reported AIDS cases have been male dominated (93 percent), yet new cases reported for 1997 and 1998 show that cases reported among women accounted for 10 percent of all cases.

While only 6 percent of the county's total population are African American, 12 percent of cumulative AIDS cases and 17 percent of recent cases have been among this racial group. In addition, Hispanics account for 29 percent of recent AIDS cases yet only 24 percent of the county's total population.

Seventy-seven percent of cumulative reported AIDS cases have been attributed to men having sex with men (MSM), yet that number has declined to 70 percent of recent cases (1997 and 1998). Meanwhile, among recent AIDS cases, more people have attributed their HIV infection to injection drug use (12 percent) and heterosexual sex (8 percent) than cumulative AIDS cases (8 percent and 4 percent, respectively).

The majority of AIDS cases reported in the county have been reported in Central San Diego (65 percent), although that number has declined among recent cases (1/97 to 8/99) to 59 percent. South Bay reported only 8 percent of the cumulative AIDS cases yet 13 percent of recent cases.

Homeless persons living with AIDS in San Diego County are most likely to be African American, male, gay or lesbian, and reside in Central San Diego.

HIV/AIDS Housing Inventory

This section outlines the available housing stock and financial assistance programs restricted to serving people living with HIV/AIDS in San Diego County. It also discusses the financial resources being used for HIV/AIDS housing and how this money is being spent.

The HIV/AIDS-specific housing resources available in San Diego County, outlined in this section, do not and *cannot* meet the housing needs of all people living with HIV/AIDS. Clearly, many people living with HIV/AIDS have their housing needs met through other housing options, such as their own homes, apartments on the open market, public or other low-income housing, or doubling-up with friends or family.

The housing market in San Diego County is becoming too expensive for many of the county's low-income residents. It is within this context that the AIDS housing system operates. Therefore, it is important to review this section in conjunction with the "Housing and Homelessness" section on page 5 of this plan. This section summarizes the funding available through the HOPWA program and AIDS housing resources available in San Diego County.

HIV Housing Committee

Established in 1994 as a subcommittee of the HIV Health Services Planning Council, the HIV Housing Committee serves as an advisory body to the County of San Diego Department of Housing and Community Development (HCD) and is the primary means of community participation in the planning and decision-making process for HOPWA (Housing Opportunities for Persons with AIDS) funds allocated to the region by the U.S. Department of Housing and Urban Development (HUD) each year for HIV/AIDS housing. The Committee also provides guidance on unmet needs and recommendations for improving the efficiency of service delivery. The Committee conducts business at monthly public meetings held in central San Diego.

The Committee consists of 23 persons representing diverse professional, community, and consumer interests in HIV housing. The Committee includes a minimum of four HIV-positive persons. Other interests represented on the Committee include housing finance, non-profit housing development, public housing agencies, housing for the homeless, post-incarcerated persons, communities of color, gays and lesbians, women, families and children, hemophilia, tuberculosis, alcohol and drug abuse, developmentally and physically disabled.

HOPWA Funding

The County of San Diego receives Housing Opportunities for Persons with AIDS (HOPWA) funding directly from the U.S. Department of Housing and Urban Development (HUD). *Table 14* presents the amount of HOPWA funds received each year since 1993, the first year San Diego received HOPWA funding.

Table 14
San Diego County HOPWA
Formula Allocation

Year	Formula Allocation
FY 1992	$535,000
FY 1993	$1,245,000
FY 1994	$2,053,000
FY 1995	$1,912,000
FY 1996	$1,721,000
FY 1997	$2,101,000
FY 1998	$2,092,000
FY 1999	$2,168,000
Total	**$13,827,000**

The HOPWA program provides grant funds to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of low-income people living with HIV/AIDS and their families. The HOPWA program currently provides funding for the following housing activities for people living with HIV/AIDS: transitional housing (5 community residences), long-term supportive care housing (2 community residences), independent transitional housing (1 chemical dependency community residence), long-term scattered-site housing (rent subsidy program), and acquisition/rehabilitation project-based housing (3 housing programs). Additionally, HOPWA also funds affordable housing information/referral services, moving services, and residential services coordination activities for people living with AIDS (PLWAs). ***Table 15*** shows how these funds have historically (FY 1992 to FY 1998) been allocated by use of funding.

Table 15
Historical Allocation of HOPWA Funds, by Use of Funding
(FY 1992 to FY 1998)

Use of Funding	Percent of Funds
Rental assistance (long-term)	31%
Housing development (acquisition/rehab/new)	29%
Operating costs	26%
Supportive services	7%
Information and referral	4%
Rental assistance (short-term)	2%
Resource identification	1%
Technical assistance	<1%

Current AIDS Housing Resources

Site visits were made to six facility-based HIV/AIDS and low-income housing programs, including mental health and chemical dependency recovery residential programs. Staff from at least six other AIDS service organizations were interviewed about the housing resources available to their clients. The following is a summary, based on information gathered from site visits, the U.S. Department of Housing and Urban Development, San Diego County Department of Housing and Community Development, and Townspeople, of housing resources available to people living with AIDS in San Diego County.

Information and Referral

Information and referral services are provided to individuals and families living with HIV/AIDS to assist in their searches for clean, safe, affordable housing and other important human services and entitlements.

During 1998, Townspeople, Inc. responded to 5,716 requests for information and services for men, women, and families with children disabled by AIDS. Townspeople operates the Community Outreach Program, which is extending information and referral services to North County, East County, and South Bay; provides biweekly affordable rental listings; monitors availability at local group homes; and produces manuals that help clients find affordable housing.

Emergency Housing

Emergency housing is intended to keep people with HIV/AIDS off the street when they are confronted with an immediate loss of housing, or are already homeless. The core of emergency housing in most communities consists of homeless shelters. Additional emergency resources can include hotel or motel vouchers, short-stay apartments, and group living situations. Agencies may obtain long-term leases on these apartments or homes to use them as emergency shelter for homeless individuals or families.

Ryan White CARE Act funds ($208,000 per year) are used to fund an Emergency Assistance Pool. Sixty to 70 percent of these funds are allocated for rent and/or security deposits.

In addition, there is a hotel/motel voucher program funded with Federal Emergency Management Act (FEMA) funds, and four non-AIDS-specific emergency shelters for the homeless: Good Samaritan Shelter, Hidden Valley House, Interfaith Shelter Network (seasonal), and Rachel's Night Shelter.

Transitional Housing

Transitional housing provides an interim (usually up to two years) placement for people who are not yet ready for, or do not have access to, permanent housing. Transitional housing is developed for those who are trying to gain access to, or are leaving mental health or substance abuse programs, moving out of emergency housing, or waiting to get into permanent housing. Transitional housing often requires that residents participate in service or treatment programs.

There are five transitional group homes (41 beds) and one recovery home (10 beds) in the county specifically for people living with HIV/AIDS. Additionally, an intensive case management program assisting clients with substance abuse issues provides transitional housing to 30 to 70 clients.[27] ***Table 16*** provides the number of beds available at each of the transitional housing programs.

Table 16
Transitional Housing Programs, by Number of Beds

Housing Program	Number of Beds
PACTO/Casa del Sol	9
PACTO/Casa Truax	6
St. Vincent de Paul/Josue I & II	15
St. Vincent de Paul/Josue III	11
Stepping Stone/Enya House	10
AIDS Case Management/Intensive Case Management Program	30 to 70

Permanent Supportive Housing

Permanent, affordable housing combined with a range of support services that help those with disabilities—including mental illness, substance abuse, physical disabilities, and HIV/AIDS—stabilize their lives and live as independently as possible.

[27] The AIDS Case Management/Intensive Case Management Program is a one-year pilot program to directly purchase private short-term housing for homeless or post-incarcerated individuals who have been dually diagnosed with HIV/AIDS and substance and/or alcohol addiction.

Permanent supportive housing options in San Diego County include rental subsidies (30 to 70 units) and facility based programs (33 units). ***Table 17*** provides the number of units available through each of the permanent supportive programs.

Table 17
Permanent Supportive Housing Programs, by Number of Units

Housing Program	Number of Units
Shelter Plus Care (rental subsidy)	30 to 70
SBCS/La Posada*	12
Community Housing of North County (Marisol)**	21

*Note: La Posada has 12 units set aside for women with children.
**Note: Marisol has 10 units set aside for homeless individuals or families.

Permanent Independent Housing

Housing that does not place a limit on the length of time a resident is able to live there. Within this broad category, there are many different housing programs and housing types, such as small group homes, single room occupancy residential hotels, and individual homes/apartment units, either clustered in one building or scattered throughout the community.

Permanent independent housing options in San Diego County include shallow and deep rental subsidies and a facility-based housing program. ***Table 18*** provides the number of units available through each of the permanent independent programs.

Table 18
Permanent Independent Housing Programs, by Number of Beds

Housing Program	Number of Subsidies/Year or Units
Tenant-based rental assistance (TBRA) program[28]	100 subsidies
Partial assisted rental subsidy (PARS) program[29]	260 subsidies
Townspeople (Wilson Apartments)	8 units

Residential Care Facilities for the Chronically Ill (RCF-CI)

Residential Care Facility for the Chronically Ill (RCF-CI) is a California State licensure category that provides supportive housing to people living with HIV/AIDS. The California State Department of Social Services (DSS) requires that residential programs providing housing to persons with HIV disease who need care and supervision must be licensed under this category.

As ***Table 19*** demonstrates there are two RCF-CI facilities in San Diego County, each providing supportive housing to people living with HIV/AIDS.

[28] See glossary for eligibility requirements.
[29] See glossary for eligibility requirements.

Table 19
Residential Care Facilities for the Chronically Ill (RCF-CI), by Number of Beds

Housing Program	Number of Beds
Fraternity House (RCF-CI)	8
Michaelle House (RCF-CI)	12

New Developments

Currently, there are two new development projects in San Diego County. The first is a new construction project developed by Stepping Stone. It will be constructed on the site of their current drug and alcohol treatment center and will provide 28 beds for individuals with chemical dependency issues. Fourteen of these beds will be designated for people living with HIV/AIDS who also face chemical dependency challenges. The project is expected to be open in April 2000. The fourteen new beds supplement the ten beds that Stepping Stone also provides through its independent rehabilitation community residence.

A second project, Mercy Gardens, will open in 2001 and is sponsored by Mercy Charities. The project involves converting and rehabilitating a former convent building located on the grounds of Mercy Hospital in the Hillcrest neighborhood. The facility will include 23 apartment units, including 12 one-bedroom units, 10 studio units, and 1 two-bedroom apartment manager's unit. The facility is specifically for persons living with HIV/AIDS who have incomes at 50 percent of area median income or below. Rents will not exceed 30 percent of a resident's income.

Projected Need

Every community struggles with how to project the amount and types of housing assistance that people living with AIDS need. There is no clear formula for such a calculation. However, ***Table 20*** outlines projected need for HIV/AIDS housing based on a number of potential factors, including income, homelessness, and HIV status. If need were projected by considering the smaller estimates of low-income people living with AIDS, homeless persons, and those who were HIV-positive who needed assistance (2,109 persons) compared to existing housing units/subsidies (532-612), there would be a gap of more than 1,497-1,577 housing units/subsidies. If mid-range estimates for those three factors (4,744 persons) were compared to available resources, estimated need would be approximately 4,132-4,212 housing units/subsidies. And if the higher estimates (10,755 persons) were compared to available resources, estimated need would be more than 10,143-10,223 housing units/subsidies.

Table 20
Projected Need and Current Resources

	Current Data	Projected Need
Number of people living with AIDS as of February 28, 1999[30]	4,219	
Percent of people living on less than $14,400/year[31]	79%	
Estimated number of **low-income** people living with AIDS	3,333	
If 25% need assistance		833 units
If 50% need assistance		1,667 units
If 75% need assistance		2,500 units
Estimated number of **homeless** individuals on any night[32]	15,000	
Projecting 2% HIV+		300 units
Projecting 5% HIV+		750 units
Projecting 10% HIV+		1,500 units
Estimated number of **HIV-positive** individuals in San Diego County[33]	9,762-13,510	
If 10% need housing assistance		976-1,351 units
If 20% need housing assistance		1,952-2,702 units
If 50% need housing assistance		4,881-6,755 units
Current Available Subsidies/Units		
AIDS Case Management (ACM) homeless project	30-70	
Transitional housing units dedicated for people living with AIDS	51	
Partial assisted rental subsidy (PARS)	260	
Tenant-based rental assistance (TBRA) program[34]	100	
Shelter Plus Care	30-70	
Number of permanent subsidized housing units dedicated for people living with AIDS	41	
Residential Care Facilities for the Chronically Ill (RCF-CI) beds dedicated for people living with AIDS	20	
Total Subsidies/Units	532-612	

[30] San Diego County Department of Health and Human Services.
[31] 1998 Ryan White Consumer Needs Assessment. It is important to note that this survey included respondents who were HIV positive as well as those who have an AIDS diagnosis.
[32] These estimates have been used in previous AIDS Housing of Washington AIDS housing plans, and are based on various studies.
[33] San Diego County Department of Health and Human Services.
[34] There are 450 people on the TBRA waiting list.

Consumer Survey Results

This chapter incorporates the results of three consumer surveys conducted in the past year: the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Consumer Survey and the 1998 and 1999 HIV/AIDS Needs Assessment Consumer Surveys, conducted by the San Diego County Office of AIDS Coordination. Each survey provides insight into the critical issues facing people living with HIV/AIDS in San Diego County. The chapter is divided into four parts: this Plan's Consumer Survey results; selected results from the 1998 HIV/AIDS Needs Assessment Consumer Survey; selected results from the 1999 HIV/AIDS Needs Assessment Consumer Survey; and an analysis of the results from the three surveys.

Strategic HIV/AIDS Housing Plan Consumer Survey Results

For the development of the *San Diego Countywide Strategic HIV/AIDS Housing Plan*, approximately 470 HIV/AIDS housing surveys were distributed throughout the county to people living with HIV/AIDS who were receiving housing assistance through the County's HOPWA program. Surveys (in English and Spanish) were distributed to recipients of housing assistance through the County's HOPWA program. (A copy of the survey tool can be found in Appendix 2.)

The primary purpose of the survey was to determine the housing needs and preferences of people living with HIV/AIDS, in order to help guide the maintenance of, and potential additions to, the HIV/AIDS housing continuum in San Diego County.

Methodology

This survey utilized a convenience sample that included targeted outreach as described above. The majority of information is presented as "frequencies," or the number of times that a response was given by respondents. Some of the results have been "cross tabulated" to determine possible differences between respondent cohorts. In these cross tabulations, results are reported as "statistically significant" at .01 or below. This means that there is less than 1 percent probability that the relationship identified could be due to chance alone.

The results of this survey are but one of several sources of information gathered to help paint a picture of HIV/AIDS in San Diego County and are best utilized as a reference point in the overall planning process.

A total of 226 completed surveys were returned for analysis. Some individuals did not respond to one or more questions. Because the number of non-responses varies from question to question, ***unless otherwise noted, all percentages listed in the Consumer Survey section of*** **the San Diego Countywide Strategic HIV/AIDS Housing Plan** ***represent percentages of the entire sample of 226 survey respondents.*** *This presentation of the analysis is a more stable basis for comparison of responses to survey questions.*

While the survey pool represents approximately 48 percent of those 467 households receiving HOPWA housing assistance, it represents only 3 percent of the total number of individuals believed to be living with HIV/AIDS in San Diego County. A companion survey of people living with HIV/AIDS was conducted by the Office of AIDS Coordination from March-May 1999.

Compared to the demographic profile of those living with HIV/AIDS in the county[35], the survey sample proportionately included:

- more women;
- more Caucasians;
- more Hispanics;
- fewer African Americans; and
- an older subset.

These demographic differences are not the result of targeted outreach; the differences merely reflect the demographics of those eligible for and receiving HOPWA housing assistance who returned their completed surveys. More specific comparative information is included in the text below.

Survey Results

Respondent Demographics

Gender and sexual orientation

Eighty-four percent of respondents were male, 14 percent female, and 2 percent transgendered. The percentage of female survey respondents is twice the percentage of women known to be living with AIDS in San Diego County (7 percent). The highest percentage of respondents (63 percent) were gay men, while 21 percent were heterosexual, 10 percent bisexual, and 1 percent lesbian. Five percent of respondents did not indicate a sexual orientation.

Race

The majority (58 percent) of respondents identified as Caucasian; 21 percent as Hispanic; 9 percent as African American; 7 percent as Multiracial; 3 percent as Native American; 2 percent as Asian or Pacific Islander; and 1 percent as "other." Compared with the profile of people living with AIDS in the county, there were higher percentages of Caucasians and Hispanics and fewer African Americans among respondents.

Caucasian men comprised 52 percent of the respondents, while close to 32 percent of respondents were racial minority men, including Hispanics (15 percent). Five percent of all respondents were Caucasian women and 9 percent were racial minorities, including Hispanics (5 percent).

[35] San Diego County AIDS Epidemiology Report, January 1999, Volume III, No. 1.

Twelve percent (31) of respondents indicated that their primary language was other than English. Twenty-seven respondents indicated Spanish; three American Sign Language; and one "Asian."

Age

Respondents ranged in age from 10 to 67, and the average age was 41. Age ranges of respondents included:

- less than 1 percent aged 19 and under;
- 4 percent between the ages of 20 and 29;
- 38 percent between the ages of 30 and 39;
- 43 percent between the ages of 40 and 49; and
- 10 percent aged 50 and over.

When compared to the population of people living with AIDS in the county, the pool of survey respondents was older and includes a much smaller proportion of respondents between the ages of 20 and 29.

HIV status

Respondents indicated the following about their HIV status: 66 percent had received an AIDS diagnosis and were experiencing physical problems (symptomatic); 18 percent had received an AIDS diagnosis, but had no physical problems (asymptomatic); 10 percent were HIV-positive, symptomatic; and 5 percent were HIV-positive, asymptomatic.[36]

Respondents were asked to indicate which activities they believed put them at risk for exposure to HIV:

- 90 percent of respondents indicated unprotected sex;
- 18 percent indicated shared needles;
- 5 percent indicated blood products; and
- 5 percent indicated "other."

Some respondents indicated more than one activity that put them at risk.

Disability

Respondents were asked to indicate if they had a disability other than HIV/AIDS. Respondents indicated one or more disabilities, which are presented in ***Table 21***.

[36] A greater number of AIDS-diagnosed respondents are included in this survey than in the 1998 and 1999 HIV/AIDS Needs Assessment Consumer Surveys. This survey was targeted to people receiving housing assistance through HOPWA funded programs, most of which require an AIDS diagnosis to be eligible.

Table 21
Disabilities of Respondents*

Disability	Number of Respondents	Percent of All Respondents
Physical disability	53	24%
Mental illness	47	21%
Chemical dependency	24	11%
Mental illness and chemical dependency	10	4%
Developmental disability	8	4%
Deaf/hard of hearing	7	3%
Blind	7	3%
Other	25	11%

*Note: 101 respondents (45 percent) did not indicate a disability other than AIDS.

Use of Protease Inhibitors

Respondents were asked if they were currently taking protease inhibitors. Sixty-nine percent (156) of all respondents indicated that they were taking protease inhibitors. Men (60 percent) were more likely to be taking protease inhibitors than women (52 percent), while Caucasian, Hispanic, and "other" racial group respondents were more likely to be taking protease inhibitors (ranging from 68 to 71 percent) than African Americans (60 percent).

There were statistically significant differences in the use of protease inhibitors by respondents of various income levels. Fifty-six percent of respondents with incomes less than $600 per month were taking protease inhibitors, compared with 63 percent of individuals earning between $601 and $700, 74 percent of those earning between $701 and $1200, and 82 percent of individuals earning $1,200 per month or more.

Respondents were asked how long they had been taking protease inhibitors, how they rated their health since starting on protease inhibitors, if they were currently working or were planning to return to work, and if they had moved, or planned to move, because they are feeling better.

- 42 percent of all survey respondents had been taking protease inhibitors for more than two years, 12 percent for 1 to 2 years, 5 percent for 7 to 12 months, and 5 percent for six months or less.
- 44 percent of all survey respondents described their health as "better" since starting on protease inhibitors, 18 percent described their health as about the same, and 6 percent described their health was worse.
- 40 percent indicated they were not planning to return to work, 12 percent were planning to return to work, and 16 respondents (7 percent) were currently working.
- 8 percent of respondents indicated that they were planning to move because they are feeling better.

Respondents who were not taking protease inhibitors were asked to indicate the reason:

- 26 percent could not access protease inhibitors or had no funding;
- 9 percent could not tolerate the protease inhibitors or there were too many side effects;
- 8 percent did not want to take them at this time;
- 6 percent of had not received a recommendation from their doctors; and
- 3 percent could not comply with the regimen.

History of Incarceration

Thirty-eight percent of all respondents indicated that they had been in jail, prison, or county lock-up at some point in their lives. Forty-two percent of Caucasian respondents had been incarcerated, a much higher rate than among the other racial groups (35 percent for African Americans and 29 percent for Hispanics).

Discrimination

Respondents were asked if they had ever experienced discrimination in obtaining housing, or been denied housing based on a list of factors. Thirty-nine percent (89) of all respondents indicated that they had experienced some form of housing discrimination, and ***Table 22*** presents the types of discrimination indicated.

Table 22
Housing Discrimination Experienced by Respondents*

Type of Discrimination	Number of Respondents	Percent of All Respondents
Poor credit rating	66	29%
HIV/AIDS	26	12%
Gay/Lesbian	26	12%
Race	13	6%
Criminal history/prison record	10	4%
Children/family size	4	2%
Other reason	10	4%

*Note: 124 respondents (55 percent) indicated they had not experienced discrimination in getting housing. 14 respondents (6 percent) did not respond to this question.

Current Living Situation

Respondents were asked with whom they lived. ***Table 23*** below details the current living situation of respondents.

Table 23
Current Living Situation of Respondents*

Current Living Situation	Number of Respondents	Percent of All Respondents
Alone	91	40%
Friend(s)/roommate(s)	38	17%
Spouse/partner	34	15%
Parent(s)/family	15	7%
Children and no other adults	16	7%
Spouse/partner and children	6	3%

*Note: 32 respondents (14 percent) did not respond to this question.

Household size and composition

Respondents were asked to indicate their household size. Seventy respondents (31 percent) did not answer this question.

- 31 percent of respondents indicated households of two members;
- 13 percent indicated households of one member;
- 6 percent indicated households of six members;
- 5 percent had three members;
- 5 percent had four or five members;
- 4 percent had eight members; and
- 4 percent had nine or more members.

The average household size was 3.3. Women respondents had a higher average household size than men (3.9 members for women and 3.2 for men), while Hispanics had the highest average household size among racial groups (4.1 members).

One-quarter of respondents indicated that they lived with another HIV-positive person. Of those, 14 percent were friends/roommates, and 9 percent were partners. One percent (2 respondents) lived with HIV-infected children.

Dependent children

Eight percent (19) of respondents indicated that dependent children were members of their households, including 7 respondents who support 3 or 4 children.

Current Housing

The largest number of respondents rented their homes. ***Table 24*** presents all of the types of housing indicated as current residence by respondents.

Table 24
Current Housing Situation of Respondents*

Current Housing Situation	Number of Respondents	Percent of All Respondents
Rent house/apartment/condominium/mobile home	162	72%
HIV/AIDS housing facility or building	38	17%
Rent room in house	8	4%
Own house/condo/mobile home	6	3%
Hotel/motel*	5	2%
Homeless, on the streets, in a car, vacant building, etc.*	1	<1%
Drug or alcohol treatment center	1	<1%
Shelter*	1	<1%
Staying for free or "crashing" with friends/relatives*	1	<1%
Hospital or skilled nursing facility	1	<1%
Other	2	1%

*Note: Individuals on the streets, in shelters, in residential hotel/motels and those "crashing for free" are considered homeless or at risk of becoming homeless.

The majority of respondents (63 percent) had lived in their current housing for more than one year, including 82 respondents (36 percent) that had been in their current residence for 1 to 2 years. Eighteen percent had lived in their current housing for 7 to 12 months, 14 percent had lived in their housing for 1 to 6 months, and 5 percent had lived in their housing for less than one month.

Rental assistance

Eighty-three percent of respondents were currently receiving some sort of rental assistance:

- 59 percent received Partial Assistance Rental Subsidy (PARS);
- 16 percent received rental assistance through HOPWA;
- 4 percent received Section 8; and
- 5 percent received rental assistance from other sources.

Ninety-three respondents (41 percent) were on waiting lists for rental assistance, including Section 8 (33 percent), HOPWA (8 percent), Shelter Plus Care (3 percent) and other waiting lists (4 percent). Of respondents who indicated they were on waiting lists for Section 8 rental subsidies, 69 percent had been waiting for over two years. Some respondents indicated that they were on more than one housing assistance waiting list.

More than one-third (84 respondents or 37 percent) of respondents indicated they received their current housing because they had HIV/AIDS. Thirty-eight respondents (17 percent) indicated they were living in HIV/AIDS-specific housing.

City of residence

The majority of respondents (72 percent) lived in the City of San Diego. Respondents are grouped according to city of residence in ***Table 25***.

Table 25
City of Residence of Respondents*

City	Number of Respondents	Percent of Respondents
San Diego	163	72%
Oceanside/Camp Pendelton	15	7%
Escondido	12	5%
Vista	8	4%
Chula Vista	4	2%
National City	4	2%
El Cajon	3	1%
Imperial Beach	3	1%
Lakeside	2	1%
Carlsbad	1	<1%
Encinitas	1	<1%
Lemon Grove	1	<1%
Ramona	1	<1%
San Marcos	1	<1%
San Ysidro	1	<1%
Spring Valley	1	<1%

*Note: 5 respondents (2 percent) did not respond to this question.

Rent and Expenses

Respondents spent various amounts on rent or mortgage—ranging from nothing (12 respondents or 5 percent) to more than $700 per month (3 respondents or 1 percent). The median rent/mortgage payment (the point at which half of respondents paid less and half paid more) was $325 per month, while the average rent was $331. Male respondents paid more on average for rent/mortgage than women ($338 to $302), while African American ($358) and Caucasian respondents ($351) paid much more than Hispanic respondents ($281).

Over half of respondents would have to move if their rent or mortgage payment went up by $50. Ten percent of respondents spent an additional $100 or more per month on utilities.

Fifty-six percent of the respondents that indicated their income and rent (127 respondents) had a "cost burden" (reported spending more than 30 percent of their income on rent), and 32 percent (72 respondents) reported spending more than 50 percent of their income on rent, and therefore had a "severe cost burden" and are considered at risk of homelessness. The median percentage of

income spent on housing costs by respondents was 44 percent, while the average percentage was 51 percent. Male respondents spent more of their income on housing than women (52 percent to 41 percent) while Caucasian respondents (53 percent) paid more than African American (51 percent) and Hispanic respondents (46 percent).

Out-of-pocket medical costs range from $0 to $657 per month. Forty-eight percent of respondents spent nothing out-of-pocket for medical expenses, while approximately 17 percent spent $100 or more per month for medical expenses.

Benefits and Assistance

Table 26 reflects the financial benefits received by respondents.

Table 26
Benefits Received by Respondents

Benefit Received	Number of Respondents	Percent of All Respondents
SSA/SSDI (Social Security Disability Insurance)	131	58%
SSI (Supplemental Security Income)	129	57%
MediCal/Cal-Optima	121	54%
Medicare	100	44%
ADAP (AIDS Drug Assistance Program)	42	19%
Waiver services (HIV/AIDS Home and Community Services)	35	16%
Veteran's benefits or retirement	15	7%
Food stamps	10	4%
Private health insurance	8	4%
Private disability insurance	4	2%
TANF (Temporary AID to Needy Families)	5	2%
General Relief	3	1%

The income and benefits received by 14 percent of respondents helped to support other people including: young children (11 percent), a partner (3 percent), parents (3 percent), adult children (1 percent), grandchildren (<1 percent), and others (<1 percent). Women were more likely than men and Hispanics were more likely than other racial groups to be supporting other people with their income and/or benefits.

Monthly Household Income

Household income ranged widely for respondents and varied by race and gender. The median household income (the point at which half of respondents' households earned less and half earned more) was $712 per month, while the average monthly household income was $1,132. More than three-quarters of respondents had monthly household incomes of less than $1,000. Eight respondents indicated a monthly household income of $676, California's SSI award level, while 71 respondents (31 percent) earned between $600 and $700 per month. Eleven respondents

indicated that their household earned $0 per month. ***Table 27*** reflects household income ranges reported by all respondents.

Table 27
Monthly Household Income Reported by Respondents*

Monthly Household Income Range	Number of Respondents	Percent of All Respondents
No income	11	5%
$1–300	4	2%
$301–600	12	5%
$601–700	71	31%
$701–1,200	66	29%
$1,200 or more	38	17%

*Note: 24 respondents (11%) did not respond to this question.

The mean household income was significantly different for male, Caucasian, and Hispanic respondents as compared to female and African American respondents. Mean monthly household incomes were as follows:

- $1,202 for Hispanic respondents;
- $1,119 for Caucasian respondents;
- $770 for African American respondents;
- $1,179 for male respondents; and
- $877 for female respondents.

Prior Homelessness and Housing

Forty-five percent of all respondents (102) indicated that at some point in their lives they had been homeless or without a regular place to stay the night. During the last three years, 20 percent of all respondents (44) had been homeless once or twice, and 7 percent (15) had been homeless three or more times. The number of episodes of homelessness in the last three years was as high as ten for one respondent.

Respondents indicated the length of their most recent period of homelessness:

- 10 percent had been homeless for more than a year;
- 9 percent had been homeless for 2 months to 1 year;
- 16 percent had been homeless a few weeks to a month; and
- 8 percent had been homeless a few days to a week.

Respondents also indicated the reason for their most recent episode of homelessness: lost income from a job or benefits (18 percent); family/partner/roommate made the respondent move (10 percent); eviction (9 percent); newly arrived in the area and had no resources (8 percent); released from jail, prison, or county lock-up (6 percent); or had been living in a substandard building (1 percent). Another 9 percent indicated another reason for their most recent episode of

homelessness, including 3 respondents who indicated that drug use was the reason they became homeless.

Fifty-three percent of female respondents indicated that they had been homeless, a higher percentage than male respondents (46 percent), while Caucasians (50 percent) and African Americans (50 percent) were much more likely to have been homeless than Hispanic respondents (31 percent).

Respondents were asked if they had to sleep outdoors, in a car, a shelter, at a friend's house, or trade sex for a place to sleep or for rent money since they had learned of being HIV-positive. Forty-seven percent of respondents (105) indicated they had not needed to do any of these things. ***Table 28*** summarizes the percentage of respondents who had to engage in these activities for a place to sleep.

Table 28
Activities Respondents Engaged in to Find a Place to Sleep Since Being Diagnosed HIV-positive*

Activities	Percentage of All Respondents Taking Part in Activity
Slept at a friend's place	37%
Slept at a shelter	20%
Slept outside	20%
Slept in a car	16%
Traded sex for a place to spend the night or for rent money	14%

*Note: 4 respondents (2%) did not respond to this question.

These findings clearly indicate that a high number of respondents have put themselves, or others, at risk due to a lack of permanent housing.

Moves since learning of HIV status

Fifty-nine percent of respondents (134) had moved since learning of their HIV status. The most frequently cited reason for moving was inability to pay the rent. However, respondents moved for a wide variety of reasons, which are summarized in ***Table 29***. Some respondents indicated more than one reason for moving. Twenty-five percent (57) of respondents had moved once or twice in the last year, and 22 percent (49) had moved from three to twenty times in the last three years.

Housing stability is widely believed to be essential to an individual's ability to adhere to strict HIV treatment protocols and is, therefore, important for people at all stages of the disease continuum.

Table 29
Reasons Respondents Moved Since Being Diagnosed HIV-positive*

Reason for Moving	Number of Respondents	Percent of All Respondents
No longer had enough money to pay the rent	59	26%
To a place they liked better	42	19%
To be *closer* to HIV/AIDS-related services, including the doctor	35	15%
To get *better* HIV/AIDS-related services, including the doctor	32	14%
To get away from their old neighborhood	28	12%
To live in a safer neighborhood	26	12%
Had been evicted	25	11%
Couldn't live independently any longer	24	11%
To remain clean and sober	22	10%
For financial or physical support from friends or family	22	10%
To be closer to family	21	9%
Asked to move because they were HIV-positive	13	6%
Released from jail or prison	9	4%
Asked to move due to drug/alcohol use	8	4%
To find a job	5	2%
Other reason	17	8%

*Note: 89 respondents (39 percent) indicated that they had not moved since learning of their HIV status. 3 respondents, (1 percent) did not respond to this question.

Alcohol and Substance Use

Respondents were asked about current use of drugs and alcohol. More than half (60 percent) indicated that they used only prescribed medication, and no respondents indicated that they used cocaine or crack cocaine. Ten respondents indicated that they used methamphetamines/speed, three of whom injected the drug intravenously. Two respondents indicated heroin use, one of whom indicated that s/he used the drug daily.

Eighteen percent of respondents indicated marijuana use. Twelve percent of respondents used marijuana from 3 to 4 times a week to daily, while 3 percent used once or twice a week. Fifteen percent of respondents indicated they used alcohol. Seven percent of respondents indicated they used alcohol once or twice per week or less often; 5 percent used alcohol three to four times per week; 3 percent indicated daily use; and less than one percent used alcohol five to six times per week. Caucasian and male respondents were more likely than respondents from other racial groups and women to use alcohol and/or marijuana.

A total of 34 respondents (15 percent) indicated that they were currently active in a drug or alcohol treatment program:

- 13 percent were participating in a twelve-step program;
- 4 percent were receiving drug-free outpatient counseling;

- 1 percent were in a residential rehabilitation program;
- 1 percent were in methadone treatment; and
- 3 percent were in other treatment programs.

Respondents were asked if they wanted or needed drug and alcohol treatment but were not receiving it and were asked to list the reasons why. Respondents indicated a wide variety of responses, including 18 percent who indicated that they did not want treatment at this time, 2 percent who indicated that the cost of treatment is too high and/or not covered by insurance, 1 percent who didn't know who or where to call for help, and 1 percent indicated the location of treatment programs was problematic.

Mental Illness

Respondents were asked if they had ever been treated for a mental illness; 40 percent replied affirmatively. Forty-nine percent of respondents were currently receiving mental health services. Forty-two percent of all respondents were in counseling, 27 percent were currently receiving medication treatment, and 4 percent received some other form of mental health treatment.

Respondents were asked if they wanted or needed mental health services but were not receiving them and were asked to list the reasons why. Twenty percent of respondents indicated that they didn't want treatment "right now"; 5 percent indicated that no beds were available; 5 percent indicated that the location of the mental health program was problematic; 5 percent had been asked to leave a mental health program; 1 percent were on a waiting list; 1 percent indicated that the cost was too high and/or not covered by insurance; and 1 percent indicated a lack of child care.

Supportive Services

Respondents were asked if they were currently receiving supportive services other than drug treatment or mental health services—93 percent (209 respondents) indicated that they were receiving other supportive services. Eighty-four percent of respondents (189) indicated that they received more than one supportive service, including 32 percent that received 6 or more services; 32 percent that received 4 or 5 services; and 19 percent that received 2 or 3 services.

Respondents accessed a variety of other services, as ***Table 30*** demonstrates. Mental health services and drug/alcohol treatment are also included.

Table 30
Supportive Services Currently Received by Respondents*

Supportive Service	Number of Respondents Receiving Service	Percentage of All Respondents Receiving Service
Case management	177	78%
Mental health services	111	49%
Primary medical care	101	45%
Food bank	84	37%
Dental care	80	35%
Home-delivered meals	73	32%
Assisted transportation	71	31%
Homemaker services	70	31%
Nutritional counseling	49	22%
Assistance with daily activities	49	22%
Drug/alcohol treatment	34	15%
Legal services	34	15%
Benefits counseling	27	12%
Professional home health care	22	10%
Emergency drug assistance	8	4%
Emergency financial assistance	7	3%
Education/literacy program services	6	3%
Respite care	4	2%
Vocational rehabilitation/employment services	4	2%
Child care	2	1%
Life skills training	3	1%
Interpreter services	3	1%

*Note:14 respondents (6 percent) indicated that they were not receiving services other than mental health and substance use treatment. Sixteen respondents, (7 percent) did not respond to this question.

Housing Preferences

Housing preferences were cross-tabulated by gender and race to determine any differences in preferences across groups.

The information included in this section represents only those who responded to each housing preference question, not the entire survey sample, unless otherwise indicated. In each table, the number of respondents to each question is indicated.

Respondents were asked to rank various housing preferences given their current health status. Seventy-five percent of respondents indicated that, based on their current health, they were happy with their housing situation and didn't want to move. Respondents that indicated that they would like to move were asked to rank, by preference, seven housing options. Moving in with

friends and moving to live alone were ranked first or second among the majority of the respondents. More structured housing options—including a housing program with on-site services, residential hospice, or skilled nursing facility—were ranked lower for the majority of respondents.

Table 31 presents the percentage of respondents that, based on their current health status, would choose to either stay where they are or move elsewhere. ***Table 31a*** presents the percentage of times that a housing option was ranked first or second among respondents who indicated that they would like to move from their current housing situation. It is important to note that 75 percent of respondents (161) indicated that, based on their current health, they were happy with their housing situation and didn't want to move, and, therefore, are not included in Table 31a.

Table 31
Given Current Health Status,
Respondents' Housing Choice

Preference	**Total Respondents** *n=215*
Stay where they are	75%
Move	25%

Note: 11 respondents (5 percent) did not answer this question.

Table 31a
Given Respondent Wants to Move and Current Health Status, Percentage of Respondents Who Ranked Each Preference First or Second

Preference	Percentage of Respondents to This Question *n=27*	Percentage of Total Respondents *n=226*
Move to live alone	78%	9%
Live with friends or roommate	78%	9%
Live in a shared house/apt with others who have HIV/AIDS	22%	3%
Move to a housing program with supportive services on-site	11%	1%
Move to live with parents/family	7%	1%
Skilled nursing facility	4%	1%
Hospice care facility	0%	0%

Note: 199 respondents (88 percent) did not answer this question.

Respondents were also asked to rank various housing preferences if they were to get sicker from HIV or AIDS. Seventy-four percent indicated that if they were to get sicker, they would stay where they were currently living. Respondents were less likely to rank "move to live alone" first or second when considering what they would do if their health worsened. In addition, respondents were much more likely to rank first or second the supportive housing, skilled nursing, or hospice options if they were to become sicker than if their current health remained the same.

Table 32 presents the percentage of respondents that, if their health status were to worsen, would choose to either stay where they are or move elsewhere. ***Table 32a*** presents the percentage of times that a housing option was ranked first or second among respondents who indicated that, if they were to become sicker, they would like to move from their current housing situation. Again, the majority of respondents (77 percent or 166 respondents) indicated that if they were to get sicker, they would stay where they were currently living, and, therefore, are not included in Table 32a.

Table 32
Given Worsening Health Status,
Respondents' Housing Choice

Preference	Total Respondents *n=217*
Stay where they are	77%
Move	23%

Note: 9 respondents (4 percent) did not answer this question.

Table 32a
Given Respondent Wants to Move and
a Worsening Health Status,
Percentage of Respondents Who Ranked Each Preference First or Second

Preference	Percentage of Respondents to This Question *n=28*	Percentage of Total Respondents *n=226*
Live with friends or roommate	54%	7%
Move to live with parents/family	43%	5%
Move to live alone	39%	5%
Live in a shared house/apt with others who have HIV/AIDS	18%	2%
Move to a housing program with supportive services on-site	18%	2%
Hospice care facility	14%	2%
Skilled nursing facility	14%	2%

Note: 198 respondents (88 percent) did not answer this question.

Shared housing

Respondents were asked how they would feel about living in an apartment building designed to house people with a mix of disabilities, including people with mental illness, people with chemical dependency problems, and people living with HIV/AIDS. Response options were "like," "don't care," and "dislike." Responses were cross tabulated by gender and race.

The overwhelming majority of all respondents and all cohorts of respondents "dislike" the idea of living with other people living with HIV/AIDS, chemical dependency, and/or mental health problems. Male respondents "disliked" the shared housing option more than female

respondents, while African American and Caucasian respondents "liked" the idea of shared housing more than Hispanics. The responses are presented in ***Table 33***.

Table 33

Responses to Mixed-Special Needs Housing Options, by Gender, Race, and All Respondents

Response	**Total Respondents** *n=211*	**Male** *n=178*	**Female** *n=29*	**Caucasian/ White** *n=123*	**Hispanic/ Latino** *n=44*	**African American** *n=19*
Like	9%	8%	17%	10%	5%	11%
Don't Care	25%	25%	24%	24%	27%	21%
Dislike	66%	67%	59%	66%	68%	68%

Neighborhood characteristics

Responses from 62 percent of all respondents (141) were included in the data analysis for this question. Respondents were asked to rank the most important characteristics of a neighborhood if they needed to move. Living near friends and family (36 percent) was ranked as the most important neighborhood characteristic by the highest percentage of respondents, while living near the doctor (32 percent) was named as the most important neighborhood characteristic by the second highest percentage. Some respondents indicated other options as their most important neighborhood characteristic, including: living near transportation (16 percent); living near shopping (14 percent); living near workplace (2 percent); and living near child care (1 percent).

Home characteristics

Responses from 60 percent of all respondents (136) were included in the data analysis for this question. Respondents were asked to rank the most important qualities about their home if they needed to move. Living in a safe neighborhood (68 percent) was, overwhelmingly, the most important characteristic identified by all categories of respondents. Some respondents indicated other qualities as their most important home characteristic, including: clean and sober housing (13 percent); near people of the same culture (14 percent); a drug tolerant setting (2 percent); and wheelchair accessibility (2 percent).

Choosing between options

Respondents were provided three pairs, or dyads, of housing options and asked to choose their preference between the two for each dyad based on their current income. African American and female respondents very clearly preferred to live independently as opposed to in a shared living environment. The results are detailed in ***Table 34*** by gender, race, and all respondents.

Table 34

Responses to Housing Option Dyads, by Gender, Race, and Total Respondents

Option	Total Respondents	Male	Female	Caucasian/ White	Hispanic/ Latino	African American
Option 1	*n=202*	*n=175*	*N=23*	*n=123*	*n=39*	*n=18*
pay more rent to have their own place, **or**	70%	70%	74%	72%	59%	78%
share a less expensive apartment or house with others	30%	30%	26%	28%	41%	22%
Option 2	*n=170*	*n=148*	*n=19*	*n=106*	*n=30*	*n=13*
move to another city for a less expensive place of their own, **or**	55%	51%	74%	45%	60%	92%
live close to their current neighborhood in shared housing	45%	49%	26%	55%	40%	8%
Option 3	*n=176*	*n=154*	*n=17*	*n=106*	*n=35*	*n=13*
live in an apartment building where only other people with HIV/AIDS live, **or**	24%	24%	12%	26%	23%	8%
live in an apartment building that mixes people with HIV/ AIDS with other residents	76%	76%	88%	75%	77%	92%

Summary

This survey, distributed to each recipient of rental assistance through the County's HOPWA program, measured the housing needs and history of San Diego County residents that were living with HIV/AIDS *and* receiving rental assistance. The results of this consumer survey are only one piece of the HIV/AIDS housing consumer-input process that has assessed the housing and services needs of people living with HIV/AIDS in San Diego County. Consumer focus groups, document review, provider and case manager surveys and interviews, public meetings, and Steering Committee input have all contributed to understanding the housing and services needs of people living with HIV/AIDS in San Diego County.

Despite the fact that the survey respondents were housed, many respondents are clearly in very precarious housing situations. For example, over half of the respondents reported spending more than 30 percent of their income on rent, and nearly one-third reported spending more than 50 percent. In addition, over 50 percent of respondents would have to move if their rent increased by $50, an indicator of being at serious risk of homelessness; and more than 50 percent of respondents earned less than $700 per month.

More than 25 percent of respondents had moved since learning of their HIV status due to an inability to pay the rent, and nearly one in four respondents had moved 3 times or more in the last three years. In addition, more than half of respondents had slept outdoors, in a car, a shelter, at a friend's house, or traded sex for a place to sleep or for rent in the time since they had been diagnosed HIV-positive, thereby putting themselves and others at risk.

Respondents to this survey are accessing services, specifically housing assistance, yet they continue to have "housing problems" and remain at risk of homelessness. While nearly 75 percent of respondents are comfortable in their current housing situations and would prefer to stay in their current housing if they were to get sicker, most are a small rent increase away from becoming homeless; and for many, it would not be the first time.

1999 HIV/AIDS Needs Assessment Consumer Survey Results

The following consumer survey results are the culmination of six months of work by the 1999 HIV/AIDS Needs Assessment Working Group, a subcommittee of the Title I/II Planning Committee, a committee of the HIV Health Services Planning Council. The purpose of the 1999 HIV/AIDS Needs Assessment was to gather information in order to re-evaluate HIV/AIDS care and treatment services in San Diego County. Data generated by this process and report will be used to help prioritize the most urgent future uses of Ryan White CARE Act and HOPWA dollars.

Differences among racial groups and by gender are discussed where available and when significant.

A summary of housing-related results of the survey are included here; for complete results, contact Dan O'Shea of the San Diego County Office of AIDS Coordination at (619) 515-6681.

Survey Respondent Demographics

In order to provide a context for the housing-related results of the *1999 HIV/AIDS Needs Assessment Consumer Survey,* as well as a comparison to the consumer survey conducted for this Plan, we present the following demographic summary of survey respondents:

- 1,322 people living with HIV/AIDS responded to this survey;
- 63% of respondents were from Central San Diego;
- 87% of respondents were male;
- 59% of respondents were Caucasian (White), 21% were Latino (Hispanic), and 13% were African American or African (Black);
- 75% of respondents were 30 to 49 years of age;
- 50% of respondents were AIDS-diagnosed, 25% HIV-positive, without symptoms, and 24% HIV-positive, with symptoms; and
- 67% were gay or lesbian (homosexual).

When compared with the demographic profile of people living with AIDS in San Diego County,[37] this survey had nearly identical gender, racial, and age breakdowns. In comparison to the survey conducted in association with the *San Diego Countywide Strategic HIV/AIDS Housing Plan*, this survey's respondents also had very similar gender, racial, and age characteristics, although the *San Diego Countywide Strategic HIV/AIDS Housing Plan* survey had more respondents with an AIDS diagnosis (84 percent).

Housing-Related Responses

Respondents were asked 7 questions about their housing status in order to determine their housing needs. These are summarized below. In addition, respondents were asked which services, including "housing/shelter", they had accessed in the past 12 months and which services they needed but couldn't get. Only 17 percent of respondents had accessed "housing/shelter" in the past 12 months. "Housing/shelter" ranked tenth out of 33 services consumers need but are not able to access. In addition, "housing/shelter" was given a priority ranking of seventh out of 33 services by respondents, down slightly from its ranking of fifth in the *1998 HIV/AIDS Needs Assessment Consumer Survey*.

Current Housing

The largest number of respondents rented their homes. ***Table 35*** presents all of the types of housing indicated as current residence by respondents.

[37] As of February 1998, using data from San Diego County Health and Human Services Agency, AIDS and Community Epidemiology, AIDS Epidemiology Unit.

Table 35
Current Housing Situation of Respondents

Current Housing Situation	Number of Respondents	Percent of All Respondents
Rent house/apartment/condominium	729	55%
Rent room in house	152	12%
Own house/apartment/condominium	149	11%
Staying for free or "crashing" with friends/relatives*	76	6%
Hotel/motel*	51	4%
HIV/AIDS group home	22	2%
Drug or alcohol recovery home or halfway house	22	2%
Homeless, on the streets, in a car, vacant building, etc.*	9	1%
Licensed residential care	8	1%
Shelter*	4	<1%
Hospital or skilled nursing facility	5	<1%
Other	46	3%

*Note: Individuals on the streets, in shelters, in residential hotel/motels and those "crashing for free" are considered homeless or at risk of becoming homeless.
Note: 49 respondents (4 percent) did not answer this question.

Survey respondents were also asked to state the length of time they had lived in their current housing, an indicator of housing stability. Twenty-four percent of respondents had lived in their current housing for less than 6 months, 33 percent had lived in their current housing for 6 months to 2 years, and 39 percent had lived in their current housing for 2 years or more.

Rent and Expenses

Table 36 shows the amount survey respondents personally spent on their rent or mortgage each month.

Table 36
Average Monthly Rent

Average Monthly Rent	Number of Respondents	Percent of All Respondents
$0	70	5%
$1 to $200	111	8%
$201 to $300	167	13%
$301 to $400	263	20%
$401 to $500	244	19%
Above $500	302	23%

Note: 165 respondents (13 percent) did not answer this question.

Respondents to the *San Diego Countywide Strategic HIV/AIDS Housing Plan* survey had more people paying $1 to $300 per month (34 percent) than this survey (21 percent) and had fewer people paying more than $500 per month (15 percent) than this survey (23 percent).

Sixty-three percent of survey respondents spent more than 25 percent of their income on housing (rent or mortgage), and 30 percent of respondents spent more than 50 percent of their income on housing.

Forty-one percent of respondents (536) said that if their rent went up, they would have to move. Of those 536 respondents, 27 percent would have to move if their rent went up just $25 per month, and an additional 28 percent would have to move if their rent went up $50 per month.

Housing Preferences

Respondents were asked the following question: "If you had to move to another area to find a cheaper house or apartment, where would you be willing to live?" Respondents were asked to select as many responses as applied from specific geographic areas of the county (Central San Diego, South Bay, etc.) and from more general geographic areas (rural, large city, or small city or town). The largest number of respondents (630 or 48 percent) said they would be willing to live in Central San Diego, while 28 percent said "in a large city." Twenty-three percent said they would be willing to live in North County (coastal area); 21 percent would live "in a small city or town"; and 19 percent would live "in a rural area." Respondents that reside in East County were more willing than other respondents to live "in a small city or town" (28 percent) and "in a rural area" (41 percent).

Homelessness/At Risk of Homelessness

Five percent of respondents were currently homeless at the time of surveying, yet many more stated that they had been without their own room or house to spend the night in the past 12 months (25 percent). Thirty-five percent of these respondents had been without their own place to spend the night for more than 2 months; 27 percent had been without their own place to spend the night for a week to 2 months; and 27 percent had been without their own place to spend the night for less than 3 days. The majority (61 percent) of respondents who had been without their own room or house in the past 12 months had stayed for free with friends or relatives, while 21 percent had stayed on the streets and 19 percent had stayed in a shelter.

Sixty percent of active injection drug using respondents and 38 percent of injection drug users in recovery had been without their own room or house in which to spend the night in the past 12 months. Other populations at-risk of becoming homeless include African American respondents (40 percent had been without their own room or house in the past 12 months), Native Americans (39 percent), the chronically mentally ill (37 percent), women, children, and youth (36 percent), and those who were HIV-positive and symptomatic (34 percent).

Substance Abuse

Fifty-nine percent of survey respondents indicated that they had a history of substance use/abuse, including injection drug use. Twenty-three percent consumed alcohol regularly, and 21 percent had used illegal drugs "once in a while" for recreation in the past 6 months. Among racial groups, Asian-American respondents were less likely to have consumed alcohol regularly (13 percent) and used illegal drugs "once in a while" for recreation (13 percent), while 34 percent of Native American respondents had used illegal drugs "once in a while" for recreation.

Mental Illness

Thirteen percent of survey respondents indicated that they suffered from chronic mental illness, while another 6 percent suffered from dementia. Twenty-one percent of Native American respondents indicated that they suffered from chronic mental illness compared to just 6 percent of Hispanic respondents.

1998 HIV/AIDS Needs Assessment Consumer Survey Results

The 1998 HIV/AIDS Needs Assessment Consumer Survey asked its respondents many of the same questions that would be asked in 1999. However, the 1998 survey asked consumers some additional housing-related questions. The responses are summarized below. Differences among racial groups and by gender are discussed where available and when significant.

Survey Respondent Demographics

In order to provide a context for the housing-related results of the *1998 HIV/AIDS Needs Assessment Consumer Survey,* as well as a comparison to the consumer survey conducted for this Plan, we present the following demographic summary of survey respondents:

- 1,433 people living with HIV/AIDS responded to this survey;
- 62% of respondents were from Central San Diego;
- 83% of respondents were male;
- 57% of respondents were Caucasian (White), 19% were Latino (Hispanic), and 14% were African American or African (Black);
- 71% of respondents were 30 to 49 years of age;
- 47% of respondents were AIDS-diagnosed, 28% HIV-positive, without symptoms, and 22% HIV-positive, with symptoms; and
- 60% were gay or lesbian (homosexual).

When compared with the demographic profile of people living with AIDS in San Diego County,[38] this survey had nearly identical gender, racial, and age breakdowns. In comparison to the survey conducted in association with the *San Diego Countywide Strategic HIV/AIDS Housing Plan*, this survey's respondents also had very similar gender, racial, and age

[38] As of February 1998, using data from San Diego County Health and Human Services Agency, AIDS and Community Epidemiology, AIDS Epidemiology Unit.

characteristics, although the *San Diego Countywide Strategic HIV/AIDS Housing Plan* survey had more respondents with an AIDS diagnosis (84 percent).

Housing-Related Responses

The responses to the 11 housing-related questions that were not asked in 1999 are included here. Please note that 6 of the questions were optional and were only answered by a small portion of the survey respondents.

Housing Services

Survey respondents were asked which housing services they were currently using and which services they needed, but were not using. The results are listed in ***Table 37.***

Table 37
Housing Services Currently Used and Needed, But Not Using

Service	Percent Using Service	Percent Needing Service, But Not Using
Rental Subsidy	16%	19%
Help to Find Roommate/Affordable Housing	11%	9%
Assistance with Paying Rental Deposit	10%	12%
Assistance with Moving	9%	9%
Group Housing/AIDS Residence	5%	4%
Group Housing/Recovery	3%	3%
Emergency Shelter/Hotel	5%	4%

Waiting Lists

Many respondents were on waiting lists for rental assistance programs. Nineteen percent were on the Section 8 waiting list, 5 percent were on the tenant-based rental assistance (lottery) waiting list, 3 percent were on the Shelter Plus Care waiting list, and 3 percent were on the Partial Assistance Rental Subsidy (PARS) waiting list. Thirty-nine percent of respondents were not on a waiting list, and 6 percent were not sure which list they were on.

Discrimination

Many respondents indicated that they had experienced problems in getting housing. Respondents attributed these difficulties to bad credit (20 percent); being gay, lesbian, or transgender (9 percent); HIV/AIDS status (9 percent); poor rental history (8 percent); race (5 percent); alcohol or drug use (3 percent); criminal history or prison record (2 percent); and having children or the size of their family (1 percent).

Homelessness/At Risk of Homelessness

Seven percent of respondents indicated that they were homeless at the time of surveying, and 23 percent had been homeless in the past three years. Respondents were also asked if, in the last three years, they had ever been without a room or house in which to spend the night. Of the 259 respondents (18 percent of survey respondents) who had been without a place to sleep, 53 percent (9 percent of all survey respondents) had been in the situation three or more times. The most commonly cited reason for respondents to have been without a place to sleep was not having any money (84 percent). Other reasons that respondents had been without a place to sleep included alcohol or drug-related problems (38 percent); family/partner/roommate made the respondent move (37 percent); eviction (26 percent); newly arrived in the area and had no resources (22 percent); mental health problems (19 percent); released from jail, honor camp, or prison (12 percent); and substandard or condemned housing (8 percent). African American respondents were more likely to have been without a place to sleep (28 percent) than other racial groups, and were also more likely to cite the reason as alcohol or drug related problems (44 percent) and mental illness (21 percent).

Optional Questions

Seventeen respondents (1 percent) answered at least one of the housing-related optional questions.

Respondents were provided four pairs, or dyads, of housing options and asked to choose their preference between the two for each dyad based on their current income. The results are detailed in ***Table 38***.

Table 38
Responses to Housing Option Dyads, by Total Respondents

Option	Total Respondents
Option 1	*n=14*
pay more rent to have their own place, **or**	79%
share a less expensive apartment or house with others	21%
Option 2	*n=13*
move to another city for a less expensive place of their own, **or**	69%
live close to their current neighborhood in shared housing	31%
Option 3	*n=12*
live in an apartment building where only other people with HIV/AIDS live, **or**	17%
live in an apartment building that mixes people with HIV/ AIDS with other residents	83%
Option 4	*n=7*
have their own private sleeping room in a hotel or SRO, **or**	29%
live in shared housing with a shared bath and kitchen (roommate situation)	71%

Respondents were asked if they were willing to relocate from their present housing situation if they were able to obtain a Section 8 rent subsidy in an outlying suburb. Nine of 14 respondents answered that they would move.

Analysis

When comparing the results of the larger 1998 and 1999 HIV/AIDS Needs Assessment Consumer Survey results with the results of the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Consumer Survey, it is important to note that each respondent to the latter survey was receiving some form of HOPWA-funded housing assistance. The other surveys did not target a specific subgroup of people living with HIV/AIDS.

Despite the fact that the *San Diego Countywide Strategic HIV/AIDS Housing Plan* survey respondents receive housing assistance, many respondents remained in precarious housing situations—over 50 percent spent more than 30 percent of their income on housing costs. The 1999 Needs Assessment survey found that 63 percent of respondents spent more than 25 percent of their income on housing costs.

The 1998 Needs Assessment survey found that 35 percent of respondents indicated a need for rental assistance, yet only 16 percent were receiving rental assistance. It was also demonstrated

that current housing assistance resources, including group housing, referral and roommate services, and emergency shelter, are serving less than half of the self-identified need in the county.

Each survey found that respondents moved frequently and unwillingly, often due to an inability to pay the rent. The surveys also demonstrated that people living with HIV/AIDS are often in unstable housing situations. The *San Diego Countywide Strategic HIV/AIDS Housing Plan* survey found that more than 50 percent of respondents had slept outdoors, in a car, in a shelter, at a friend's house, or traded sex for a place to sleep since they had been diagnosed HIV-positive. The 1999 Needs Assessment survey found that 25 percent of respondents had been without their own room or house in which to spend the night at least once in the past 12 months. These findings underscore the need for continued emergency financial assistance, including Partial Assistance Rental Subsidy (PARS), as well as housing counseling, placement, and referral programs.

The 1998 Needs Assessment survey found that 9 percent of survey respondents had been without their own room or house in which to spend the night more than three times in the past three years. When asked to cite the reason they had no place to sleep, 1998 Needs Assessment survey respondents cited an inability to pay the rent (84 percent) most often, but also cited drug or alcohol related problems (38 percent) and mental health problems (19 percent). The 1999 Needs Assessment survey found that 59 percent of respondents were current or former substance abusers and 13 percent were mentally ill. Forty percent of *San Diego Countywide Strategic HIV/AIDS Housing Plan* survey respondents indicated they had been treated for mental illness. It is clear that many people living with HIV/AIDS in San Diego County have multiple problems, problems that, coupled with financial hardships, often inhibit their ability to remain or even become housed. Access to substance abuse and mental health treatment, and recovery programs remains a priority for promoting and realizing housing stability for people living with HIV/AIDS.

Provider and Case Manager Surveys

For the development of the *San Diego Countywide Strategic HIV/AIDS Housing Plan*, approximately 60 housing surveys were distributed throughout the county to HIV/AIDS case managers and 80 were distributed to housing providers and AIDS service organizations. The purpose of the surveys was to assess the housing needs of the clients served by housing and service providers and case managers in the county. Seventeen case managers and 9 providers responded.

The results of both surveys were analyzed and are presented together below. (A copy of both survey tools can be found in Appendix 2).

Overview

Case managers and housing and service providers clearly stated that their clients do not have enough housing options. Barriers to housing clients that were commonly cited among respondents were the difficulty of the application process, the insufficiency of the subsidy, the lack of knowledge about and/or access to housing assistance, and that there were too few options for housing families with children.

Respondents felt that their clients were most in need of independent housing and transitional housing options. Transportation, both to services and for use while searching for housing, was cited within the survey and also in many comments on the margins of the surveys. Many clients are also in need of alcohol/drug treatment/counseling and meals/nutrition counseling.

Methodology

Both the case manager and provider surveys utilized a convenience sample that included targeted outreach to approximately 60 case managers and 80 housing and service providers.

The results of this survey are but one of several sources of information gathered to help paint a picture of the housing needs of people living with HIV/AIDS in San Diego County and are best utilized as a reference point in the overall planning process.

A total of 17 completed case manager surveys and 9 provider surveys were returned for analysis. Some individuals did not respond to one or more questions.

Survey Results

Services Accessed

A number of questions were designed to gauge the type of services accessed by clients being served by case managers and AIDS service providers. First, providers reported the number of clients that had received housing services in the past year; answers ranged from 0 to 5,716 (through an information and referral program). Case managers were asked to indicate which services were accessed by their clients and to rank them in order of utilization. Their responses are summarized in ***Table 39***.

Table 39
Services Accessed by Case Managers' Clients, Ranked in Order of Utilization

Services Accessed	Number of Case Managers Whose Clients Access this Service
Housing information and referral	14
EARP (emergency assistance) Pool	13
PARS (shallow subsidy)	13
Emergency financial assistance	12
HOPWA/TBRA	10
Section 8 housing	9
Residential drug/alcohol treatment	7
HIV/AIDS specific housing program	7
Housing advocacy	5
Residential mental health or developmental disability programs	3
Clean and sober living housing programs	1

Barriers to Housing Assistance

Respondents to both the case manager and provider surveys were asked what they thought were the clients' greatest barriers to receiving housing assistance. Both case managers and providers indicated the greatest barrier that their clients faced was "not enough appropriate housing options" and that "language" was not a significant barrier. Other barriers were ranked quite differently by the two groups of respondents.

Results are provided in ***Table 40*** and are ranked by the number of times a respondent cited the barrier.

Table 40
Barriers to Clients' Access to Housing Assistance, Ranked by Frequency of Response

Barrier (Number of Times the Barrier was Cited by Case Managers)	Barrier (Number of Times the Barrier was Cited by Providers)
Not enough appropriate housing options (15)	Not enough appropriate housing options (5)
Clients don't know about availability (9)	Subsidy isn't enough for decent place (4)
Application process is too difficult (8)	Too few options for families with kids (4)
Too few drug/alcohol tolerant programs (8)	Providers don't know about availability (3)
Too few options for families with kids (7)	Clients don't know about availability (2)
Location of services (6)	Application process is too difficult (2)
Subsidy isn't enough for decent place (6)	Lack of client motivation (2)
Too few clean/sober programs (6)	Too few clean/sober programs (2)
Providers don't know about availability (5)	Too few drug/alcohol tolerant programs (1)
Lack of client motivation (5)	Language (1)
Language (2)	Location of services (0)

Most Needed Housing Options

Respondents were asked to rank 11 different housing options, based on which options were most needed by their clients. Both providers and case managers ranked the following three housing options as among the four most needed by their clients:

- Subsidized independent living in an apartment with no on-site services
- Transitional housing; 6-24 months with life skills/job skills training
- Long-term rental/mortgage subsidy to keep people in their own home

Results are provided in ***Table 41***, ranked by greatest to lowest clients' need by case managers and providers.

Table 41
Housing Options,
Ranked in Order from Highest to Lowest Priority Need of Clients*

Housing Option (Average Rank, 1st to 11th, by Case Managers)	Housing Option (Average Rank, 1st to 11th, by Providers)
Long-term rental/mortgage subsidy to keep people in their own home (4.1)	Subsidized independent living in an apartment with no on-site services (3.5)
Transitional housing; 6-24 months with life skills/job skills training (4.7)	Shared houses/apartments with little or no on-site supportive services (4.2)
Subsidized independent living in an apartment with no on-site services (5.0)	Transitional housing; 6-24 months with life skills/job skills training (4.3)
Clean and sober housing program (5.2)	Long-term rental/mortgage subsidy to keep people in their own home (4.5)
Shared houses/apartments with some on-site supportive services (5.3)	Emergency/short-term financial assistance for rent and utilities (5.0)
Emergency/short-term financial assistance for rent and utilities (5.9)	Clean and sober housing program (5.0)
Homeless shelter (6.4)	Shared houses/apartments with some on-site supportive services (5.5)
Shared houses/apartments with little or no on-site supportive services (6.4)	Homeless shelter (6.2)
Skilled nursing facility (6.7)	Housing program that tolerates drug/alcohol use off-premises (9.3)
Residential hospice (7.3)	Skilled nursing facility (10.2)
Housing program that tolerates drug/alcohol use off-premises (8.3)	Residential hospice (10.3)

*Note: Priority rankings were determined by overall total score for each housing option divided by the number of respondents.

Maintaining Independent Housing

Respondents were asked to rank, by order of importance, services that were needed for their independently housed clients to remain housed. Providers and case managers noted that clients needed each of the services, although many clients were not able to access some services. Both providers and case managers ranked the following three housing options as among the four most important services for their independently housed clients:

- Meals/nutrition counseling
- Transportation assistance

- Practical/chore service support

Case managers felt that transportation assistance was the most important service for clients in independent housing, while providers felt that alcohol/drug treatment counseling was most important.

Results are provided in ***Table 42***, ranked by greatest to lowest importance to independently housed clients, as perceived by case managers and providers.

Table 42
Services for Clients to Maintain Independent Housing, Ranked in Order of Importance*

Service (Average Rank, 1st to 11th, by Case Managers)		Service (Average Rank, 1st to 11th, by Providers)
Transportation assistance (2.9)		Alcohol/drug treatment/counseling (3.3)
Meals/nutrition counseling (3.6)		Meals/nutrition counseling (3.5)
Practical/chore service support (4.0)		Transportation assistance (3.8)
Personal care/hygiene assistance (4.6)		Practical/chore service support (5.8)
Protective payee/money management (4.9)		Day mental health program (6.0)
Alcohol/drug treatment/counseling (4.9)		Benefits counseling (6.0)
Day mental health program (6.6)		Personal care/hygiene assistance (6.8)
Emotional support/buddy (6.9)		Emotional support/buddy (6.8)
Benefits counseling (6.9)		Protective payee/money management (7.5)
Home health care (7.4)		Home health care (7.5)

*Note: Priority rankings were determined by overall total score for each housing option divided by the number of respondents.

Note: Respondents were asked to write in other important supportive services. One respondent indicated that "appropriate medical treatment" was the most important service needed for clients in independent housing. Other respondents indicated that "case management for domestic violence," "independent living skills," "child care," and "educational assistance" were important services for clients in independent housing.

Critical Issues

The critical issues presented below, compiled and reviewed by the Steering Committee, have been divided into four categories: system-wide, housing-specific, service-related, and advocacy (issues outside the immediate influence of the local HIV/AIDS Continuum of Care). The background section provides the context for the issues outlined in each of the categories.

Background

Vacancy rates in San Diego County are at their lowest recorded levels since they were first reported in 1958. The vacancy rates for the City and County were recently reported at 1.8 and 1.7 percent respectively. Generally, vacancy rates of less than four percent characterize a competitive rental market with an inadequate supply of housing units. At the same time, rental costs have been increasing at record rates throughout the San Diego region. As a result, there are fewer and fewer housing options for low- and very-low income households. For those persons living with HIV/AIDS who have very low incomes and rely on public entitlement programs (SSA/SSDI, GR, etc.) for their major source of income, the private housing market is an option that is increasingly out of reach. The number of people living with HIV/AIDS seeking subsidized housing options, including AIDS-specific housing, is increasing significantly.

Changes in the population living with HIV/AIDS have had significant impacts on service providers. Consumers are no longer predominantly gay white males. Women and racial minorities are increasingly impacted, as are consumers with multiple diagnoses (i.e., HIV/AIDS, mental health, chemical dependency, and chronic homelessness). In addition, an increasing number of consumers do not speak English, have criminal histories or have been incarcerated, or have personality disorders that manifest themselves in disruptive behaviors. Each of these trends significantly impacts service provider staff time and has diminished the ability of service providers to deliver effective and efficient services.

Furthermore, as a result of advances in medical treatments, people living with HIV/AIDS (PLWAs) are living longer and healthier lives. Currently, only a small percentage of PLWAs who had been unable to work are returning to work on a full-time basis with incomes that allow them to be self-sufficient. Others have expressed concern over the potential loss of benefits, fear discrimination, or have difficulty finding work that matches their qualifications. Consequently, the demand for housing among PLWAs has increased substantially faster than the ability of providers to make new units available. As a result, waiting lists for housing, especially permanent housing, have been getting longer.

Local matching funds for AIDS housing are limited because of competing demand of limited resources for special needs populations in San Diego. Due to the limited resources, the system will probably never be able to accommodate the total need for housing. Community concerns coupled with the lack of adequate transportation services countywide, are additional system-wide barriers.

System-Wide Issues

Planning, prioritization, and resource allocation together were ranked highest by the Steering Committee, followed closely by activities which will increase the capacity of providers throughout the HIV/AIDS housing and support service continuum. Coordination and collaboration are key components to the success of these endeavors.

1. **Planning, prioritization and resource allocation**. Community-based needs assessment and planning provide both the data analysis necessary for effective decision making and the framework for prioritizing certain activities, efforts, and target populations in order to build a comprehensive continuum of housing and support services. Coordination and collaboration between funding sources—including HOPWA, Ryan White CARE Act, Supportive Housing, and other federal, state, and local programs—are essential to assuring non-duplication of services and maximization of limited resources. There is also a need to review funding decisions periodically to assure that current programs adequately address current needs. Linkages with the medical, mental health, chemical dependency and criminal justice systems should be strengthened and enhanced. Planning that focuses on the housing needs of persons living with HIV must also be coordinated with local Consolidated Plan and homeless Continuum of Care activities.

2. **AIDS housing provider capacity**. Housing development and operations are complex activities requiring a broad range of skill and knowledge. Managing nonprofit organizations, complying with government contract requirements, and maintaining housing and service quality are equally challenging. New and existing HIV housing providers may need technical assistance and targeted funding to enhance their infrastructure and increase their expertise in housing development and operations, service delivery (especially in regards to mental health and chemical dependency issues), and cultural sensitivity. In collaboration with the County Department of Housing and Community Development (HCD), standards of care for housing and program evaluations may need to be developed and implemented over time.

3. **Involvement of the HIV-infected community**. Consumer input in the planning and decision-making process regarding HIV/AIDS housing is increasingly important as the epidemic evolves and the costs of housing escalate. The inclusion of people of color and women, two rising sub-populations of people living with HIV/AIDS, and the inclusion of people who have the greatest needs, such as the homeless and those with dual diagnoses, is critical to developing housing alternatives that both meet consumers' needs and respond to their housing preferences.

4. **Access to housing, services, and benefits**. The paperwork required to access services and benefits, especially housing, is burdensome for people with HIV, and consumers often don't have the skills to advocate effectively through a bureaucracy.

Housing-Specific Issues

Members of the Steering Committee felt quite strongly that it is essential to develop and **maintain a comprehensive continuum** of housing and services for residents in San Diego County. Within that framework, two urgent gaps and two development issues were identified:

5. More **affordable permanent housing units** accessible to people living with HIV are needed. The housing continuum points people toward permanent independent living to the extent possible. However, the number of both facility-based and rental voucher units dedicated and/or accessible to persons living with HIV/AIDS and their families falls far short of the need. There also continues to be a number of people who need on-site or community-based support services in order to achieve and maintain housing stability. More Residential Care Facilities for the Chronically Ill (RCF-CI) units may be needed in the county for those with needs at the highest end of the supportive living continuum.

6. **Emergency housing**, both facility-based and hotel/motel vouchers, is needed to aid those who are homeless and in urgent need of shelter. Consumers are unable to access existing public shelter accommodations and/or the programs that are available are insufficient to meet the needs of homeless people living with HIV. For some consumers, the two-week maximum stay for emergency housing is too short to complete the requirements necessary for obtaining a transitional housing placement.

7. There is a need to employ a **variety of approaches** to increase the number of units available (including units with three or more bedrooms) in non-HIV-specific complexes and through mainstream affordable housing providers. Given the high cost of housing development and preferences among consumers for mixed-population housing, these "nondevelopment" approaches can be both cost-effective and highly desirable.

8. There exist a number of **barriers to housing development** in San Diego County, including fees, complex financing and fund coordination, community concerns, and varying degrees of available resources for affordable and special needs housing development.

Service-Related Issues

In general, San Diego County has an excellent and comprehensive continuum of medical care, in terms of access to prescription drugs and social support services, and the maintenance of this quality is essential to the success of the HIV services system. However, the Steering Committee identified four key areas of concern related to maintaining the stability of residents in HIV/AIDS housing programs:

9. **There is not equal access to public transportation** in all parts of the county. Whereas there is some funding for transportation assistance, the size of the county and the uneven distribution of housing and support services within the county make transportation an ongoing concern for providers and consumers alike.

10. **Access to chemical dependency and mental health services** are also a problem. Coordination between these services and the HIV/AIDS continuum of care remains uneven and inadequate; at times they can even work at cross-purposes.

11. It is essential that residents in HIV housing programs have the ability to **maintain case management relationships**. Case management is the crucial link between the resident and the array of services available through the various medical and support service systems.

Currently, consumers may be cut off from or unable to access case management even while receiving housing assistance.

12. While not ranked as critical issues, **life/job skills and treatment adherence trainings** were identified as needed to help ensure that consumers are able to maintain their health and housing stability.

13. Increasing **child and respite care** for people living with HIV/AIDS with dependent children will enable parents to work and/or access services.

Increasing Funding and Support for HIV/AIDS Housing and Supportive Services Issues

14. The vast majority of funding for both HIV/AIDS care and affordable housing come through federal and state programs. There is a **need for effective education and outreach to community members and leaders** to ensure the continued existence of community-based programs and to increase funding to meet the increasing local need. In particular, current efforts to create a funding mechanism for the care delivered in RCF-CI licensed facilities are a top priority.

15. **Prejudice** against the poor, people of color, immigrants, gays and lesbians, and those with histories of mental illness, chemical addiction, incarceration, and/or homelessness, in addition to community concerns, are significant barriers to the siting and development of appropriate, affordable housing for people living with HIV/AIDS and their families.

16. There is a **need for improving the coordination and collaboration** at every level in the systems of funding and delivery of medical, social, housing, HIV/AIDS, job training, mental health and chemical dependency services. At the entry level, consumers do not have ready access to the array of services which they may need. Once engaged, consumers may have to be enrolled with a number of different case managers and/or attempt to negotiate the service systems themselves, a time-consuming, wasteful, and ineffective process. Ultimately the best quality and most cost-effective care and services may not be delivered because there is no one responsible or accountable for assuring that each consumer's full spectrum of needs is addressed.

Recommendations

The following recommendations have been developed based on the findings of the needs assessment and are intended to be revisited yearly as funding availability and the HIV/AIDS epidemic in San Diego County evolve.

The following recommendations were developed based on data from the needs assessment process, including consumer, provider, and case manager surveys; Steering Committee and public meetings; one-on-one interviews with key housing service providers; and consumer focus groups. At the April and May 1999 meetings of the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee, outcomes from the needs assessment were discussed and critical issues identified.

The 31 specific recommendations in this chapter are divided into four main categories: housing, service-related, system-wide, and increasing funding and support for HIV/AIDS housing and supportive services. The 13 housing strategies are grouped within three overarching recommendations:

- Actively participate in community-wide planning for housing resource allocation;
- Prioritize flexibility in increasing access to safe, affordable and appropriate housing; and
- Create and maintain a full continuum of HIV/AIDS housing options.

It is essential that AIDS housing and service providers, advocates, and people living with HIV/AIDS interact, plan, and collaborate with mainstream affordable housing and homelessness groups and processes. The needs of people living with HIV/AIDS are best met through the collaboration of these systems.

Given the dynamic nature of the HIV disease and the uncertainty of future federal funding, the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs must be revisited regularly.

Housing Strategies

Actively participate in community-wide planning efforts for housing resource allocation

It is clear that the housing needs of all people living with HIV/AIDS in San Diego County cannot be met by the resources of the HIV/AIDS housing system alone and that other low-income and affordable housing programs are necessary additional resources. Federal funds for housing and community development require coordinated planning and service delivery within participating jurisdictions. Homeless programs operate within HUD's Continuum of Care, and HOPWA-funded activities fall under the guidance of Consolidated Plans for several San Diego County

jurisdictions. For these reasons, it is essential that the needs of people living with HIV/AIDS be addressed through these systems and planning efforts.

1. This plan and its recommendations form the framework for efforts to assure housing stability and housing options for San Diego County's HIV-infected residents and their families. As such, it belongs to the people of San Diego County, and it is the duty and responsibility of community leaders to work for its full implementation.

2. People living with HIV/AIDS, AIDS housing and service providers, the cities in the county, HIV Health Services Planning Council, and members of the County HIV Housing Committee should work towards and participate in the development of regional affordable housing plans that include an emphasis on the needs of people living with HIV/AIDS and their families.

3. The San Diego County Department of Housing and Community Development (HCD), with community input and participation, should take the lead in ensuring that there is full participation by AIDS housing and service providers and consumers in Consolidated Plan, Continuum of Care, and other housing and homeless advisory and planning activities in all participating jurisdictions in the county.

4. The HCD, with community input and participation, should review the *San Diego Countywide Strategic HIV/AIDS Housing Plan* annually to assure its relevance and accuracy. This review should also include funding decisions made and programs funded to assure that current programs adequately and appropriately address current needs.

Prioritize flexibility in increasing access to safe, affordable, and appropriate housing

Although there is an enormous unmet need for housing among people living with HIV/AIDS and their families, it is an unfortunate reality that San Diego County suffers from an extreme shortage of affordable housing of all kinds. Not only is the existing housing inventory limited, but also there is little hope for a substantial increase in units affordable to very-low-income households in the near future.

It is, therefore, incumbent upon planners, funders, developers, and providers to remain flexible and poised to take advantage of opportunities to increase access to safe, affordable, and appropriate housing as they arise. At the same time, the development of special-needs and affordable housing has become increasingly complex and competitive. It may take a developer two to three years to gain approval from all the relevant government bodies and assemble the financing necessary to both complete the construction and assure long-term affordability. Thus, consumers and advocates must both express urgent need and maintain patience throughout the development process.

5. After setting priorities for new unit creation in its annual Notice of Funding Availability (NOFA) for HOPWA funding, the HCD should remain flexible as to the kind of activities that are allowable, e.g., AIDS-specific housing development, mixed-population housing development, AIDS set-asides in new or existing affordable/mainstream housing

developments, master leasing, and other "nondevelopment" strategies. HCD staff should evaluate the short- and long-term cost-effectiveness and benefits of proposed strategies.

6. In advertising the availability of HOPWA funding for new unit creation and in conducting the subsequent proposers' conferences, HCD should reach out to for-profit developers, housing authorities, and non profit affordable and mainstream housing developers to encourage their participation. HCD should also encourage these entities to increase their knowledge about the need for AIDS housing locally and HCD's willingness to be flexible in pursuing a range of development strategies.

7. Balance development with rental assistance and other nondevelopment activities. As HCD prioritizes the allocation of HOPWA and other resources towards the provision of housing for people living with HIV/AIDS and their families, every effort should be made to maintain a balance among the various housing strategies available and between short- and long-term housing needs.

Create and maintain a full continuum of HIV/AIDS housing options

It is the vision of the HCD and the Steering Committee and the mandate of the HIV Health Services Planning Council to assure the creation of a continuum of housing and services to meet the needs of people living with HIV/AIDS at all points in the disease spectrum. At the same time, the U.S. Department of Housing and Urban Development and San Diego County Department of Housing and Community Development desire the integration of HIV/AIDS housing with the homeless Continuum of Care and other affordable and special needs housing programs in the county. Towards those ends, the following recommendations articulate both a broad vision and some specific action steps. As appropriate, these actions should be taken in collaboration with the HIV Health Services Planning Council, Regional Continuum of Care Council, and the HIV Housing Committee.

8. Assure access to a range of housing options in San Diego County for people living with HIV/AIDS and their families. This includes emergency, transitional, permanent independent, and permanent supportive housing, as well as residential programs for persons with higher care needs.

9. Permanent independent housing is both the greatest single need in the county and the highest ranked housing preference among consumers.
   - To the extent possible, encourage dispersion of units where the greatest need is throughout the county. East County, central San Diego, and the South Bay have been identified as priority areas for the short term.
   - Steps should be taken immediately to increase access to units with three or more bedrooms to provide long-term housing for families impacted by HIV/AIDS.
   - Explore possible alternatives for providing some kind of "youth friendly" housing for 18- to 25-year-olds who are HIV-positive and homeless or at risk for HIV infection.

10. Maintain existing tenant-based rental assistance programs and explore potential changes that may enable more effective targeting of resources based on levels of income and need.

- Explore the possibility of requesting a shallow rent subsidy waiver from HUD for long-term HOPWA rental assistance.
- Coordinate potential HOPWA shallow rent subsidies with existing programs, including PARS.
- Maintain homelessness prevention as the primary focus of shallow rent subsidies.
- Evaluate the impacts of establishing higher income ceilings, the targeting of shallow subsidies to those with incomes between 50 percent and 80 percent of area median income, and allow for different levels of assistance as income fluctuates or to accommodate rent increases.
- Explore the possibility of establishing contracts with landlords to help tenants receiving rental assistance bridge the gap for funding deposits, and assisting those with poor credit histories to gain tenancy.
- Consider prioritizing deep subsidies for those at the lowest income levels and for families needing units with three or more bedrooms.
- Evaluate the impacts of expanding eligibility for tenant-based rental assistance to HIV-positive, non-AIDS-diagnosed consumers.
- Determine the viability of housing tenants with histories of chemical dependency in the PARS or deep subsidy programs.

11. Review existing mechanisms for providing emergency housing and determine if changes are required to existing models of delivery, operating policies and procedures, or funding levels to better assist people living with HIV/AIDS and their families as they enter and later pass through the AIDS housing continuum.
    - Improve coordination with homeless shelter providers and explore possibilities of improving last-minute access on Friday afternoons and on weekends.
    - Coordinate staff training with homeless providers to help assure that shelter staff is fully versed in HIV/AIDS issues and sensitive and responsive to the HIV-related issues faced by homeless persons living with HIV/AIDS and their families.
    - Verify the appropriateness of shelter settings for those with medication or treatment needs related to their HIV status and implement changes, as needed.
    - Explore the impacts of extending emergency assistance funding to allow time to assure seamless referral to transitional housing or other appropriate setting.
    - Tie extensions of emergency assistance to the completion of a realistic long-term housing plan.
    - Explore the implications of expanding emergency shelter options beyond central San Diego.

12. Strengthen the effectiveness of transitional housing programs through:
    - Staffing and procedural modifications that will enable them to better serve mono-lingual non-English-speaking consumers and those with mental health and chemical dependency issues;

- More closely linking transitional and permanent housing programs so that residents can be assured a smooth transition to permanent independent or supportive housing.

13. Maintain the existing Residential Care Facilities for the Chronically Ill (RCF-CI) in North County and encourage the development of a similar facility in central San Diego. Consumers, providers, advocates and planners all expressed a resounding endorsement of the ongoing need for the level of on-site care and supervision that the RCF-CI's provide. Further analysis is required in order to determine the optimal size and location for such a facility in San Diego, based on development and operational costs and siting issues.

14. Reach out to develop and maintain linkages with area skilled nursing and hospice facilities so that ready access for those who need those levels of care can be assured. Although the number of deaths from AIDS has decreased dramatically in recent years as a result of improvements in medical treatments and medication protocols, there remains an ongoing need for end-of-life care in San Diego County.

Service-Related Strategies

In order to assure the highest quality of life, health status and degree of housing stability possible, virtually all housing options for people living with HIV/AIDS and their families should include linkages to a continuum of community-based services. The HIV/AIDS continuum of care in San Diego County is well developed and offers access to the complete array of services needed. There remain, however, both significant unmet needs and opportunities for fine-tuning existing programs to better promote housing stability. As appropriate, these actions should be taken in collaboration with the HIV Health Services Planning Council.

15. HCD and other funders should require that prior to receiving funding for housing development and/or start-up of operations, providers of both facility-based and tenant-based HIV/AIDS housing programs demonstrate that services appropriate to the needs of potential residents will be provided, on-site or that community-based services are accessible to residents and formal linkages for service delivery are in place.

    - Those in independent housing may need access to community-based services, including case management, meals and nutrition counseling, job skills and life skills training, child and respite care, treatment adherence training and monitoring, transportation assistance, and medical care.
    - In addition, a range of supportive services on-site may be required in some housing programs, based on the needs of consumers, and these may include mental health services, chemical dependency treatment/recovery and/or home health care.

16. Encourage the creation of a case management task force to review case management policies and guidelines with the goal of maximizing opportunities for consumer housing stability. With the current priorities for case management services, it is possible for a consumer receiving HOPWA subsidies or residing in a HOPWA-subsidized residence to become ineligible for AIDS case management services. Given that case management is the primary point of access to the support services upon which a tenant's housing stability depends, consideration should be given to assure that, at a minimum, those receiving

HOPWA housing assistance are guaranteed ready access to case management when they need it.

17. Increase access to services for people living with HIV/AIDS outside of the City of San Diego. People living with HIV/AIDS outside of the City of San Diego may have a difficult time accessing services due to the centralization of most services in central San Diego. Increased access to services is needed, through both ongoing transportation assistance and a commitment to service availability in outlying areas, where feasible and appropriate. An outreach and subsequent educational effort is needed in the county's smaller communities to connect people living with HIV/AIDS to the services that are available to them. Consumers may also need training and ongoing support to increase their effectiveness as self-advocates.

18. Increase access to chemical dependency and mental health services, particularly for those on waiting lists for, or entering, HIV/AIDS housing programs. Consumers and providers alike indicated an unmet need in affordable and appropriate chemical dependency and mental health services. Coordination with the HIV Health Services Planning Council and the chemical dependency and mental health systems will be required and might be best addressed through existing task forces or collaborative efforts within city, county, and state government.

19. Increase access to life skills, job skills and treatment adherence trainings. For many people living with HIV/AIDS, life skills, job training, and treatment adherence education is necessary to help ensure their ability to maintain their current health and housing stability.

20. Increase access to childcare and respite care for people living with HIV/AIDS with dependent children. Medical regimens, access to appropriate support services, and navigating the various benefit systems require that custodial parents be able to leave their dependent children in appropriate child care settings for several hours or days at a time. Financial assistance and coordination of child care resources may be necessary to assure appropriate physical and mental health treatment and compliance for both parent and child. Coordination with the HIV Health Services Planning Council and other local and state programs for child support and services is encouraged.

System-Wide Strategies

The system developed for providing housing and rental subsidies for people living with HIV/AIDS and their families in San Diego County has grown substantially over the past ten years as opportunities for expanding resources appeared in response to the evolving and increasing housing needs of consumers. The primary obstacle facing the system is the huge shortfall in resources when faced with the enormous need for affordable and appropriate housing. Many consumers are daunted by the complexities of the system and the nuances of program requirements. They frequently cite their own, and providers', insufficient knowledge of the AIDS housing system as one of their greatest barriers to finding and securing housing. As the efficacy of medical treatment and medication protocols has increased in recent years, AIDS housing providers' biggest challenge is not managing residents' medical needs; rather, it is addressing their behavioral health issues. Community concerns, siting, and permit issues are real barriers faced by special needs housing developers as they attempt to respond to consumer need

and preference by creating housing and support service options geographically dispersed throughout the county. As appropriate, these actions should be taken in collaboration with the HIV Health Services Planning Council, Regional Continuum of Care Council, and the HIV Housing Committee.

21. Encourage and support continued and increased consumer involvement in the HIV/AIDS housing planning and decision-making process. Consumer input is vital both in determining the range and extent of need and in developing housing and support service options that are appropriate to and preferred by potential tenants.

22. Encourage housing developers in San Diego County to view themselves as "AIDS housing developers" and aggressively pursue options for:
    - Increasing access to safe, affordable, and appropriate housing through set-asides and other "nondevelopment" strategies; and
    - Developing new units of housing consistent with the goals of this Plan and priorities established on an annual basis by the HCD.

23. Encourage government and conventional lenders to modify and frame loan policies to encourage special needs affordable housing development.

24. Address siting and development barriers through both community education efforts and nondevelopment strategies. It is not just the difficulty in securing financing that mires the development of special needs housing projects, there are a number of barriers that can be affected by County and City governments, including development fees, permitting and siting requirements, and varying degrees of community commitment to affordable and special needs housing development.

25. Assure the quality of housing and related services provided to people living with HIV/AIDS and their families. Housing development and operation are complex activities requiring a broad range of skill and knowledge. Managing nonprofit organizations, complying with government contract requirements, and maintaining housing and service quality are equally challenging.
    - Assess the needs for technical assistance and target funding to enhance the infrastructure and increase the expertise of both existing and new AIDS housing providers in housing development and operations, service delivery (especially with regard to mental health and chemical dependency issues), and cultural sensitivity.
    - In collaboration with the Office of AIDS Coordination (OAC) and the HIV Health Services Planning Council, the HCD should develop consumer-oriented standards of care for housing and related services, including; standards for housing operations, support services and staffing levels.
    - The HCD and the Health and Human Services Agency (HHSA) should require funded agencies to implement agreed-upon standards of care and hold those agencies accountable to meet those standards. This could be phased in over a certain number of contract periods.
    - Periodic program evaluations, including consumer feedback, should be conducted over time to assure the appropriateness and quality of services delivered.

26. Examine the effectiveness of the current information and referral services and develop creative methods for further consumer and provider education. Consumers and providers alike indicated that lack of knowledge and difficulties associated with application and referral processes were barriers to housing in San Diego County.

    - Offer periodic trainings for case managers, housing providers, peer counselors, advocates, and consumers on the range of housing options and processes for accessing housing in San Diego County.
    - Explore new methods for keeping consumers and providers informed of current housing availability and opportunities, including creating and maintaining resources on the World Wide Web.
    - Simplify access to housing, services, and benefits. The paperwork required to access services and benefits, especially housing, is burdensome for people with HIV, and clients often don't have the skills to advocate effectively through a bureaucracy.

27. AIDS housing providers and advocates should expand and strengthen existing linkages to AIDS support, mental health service and chemical dependency treatment systems to ensure access to these systems for eligible consumers.

    - With the support of the HCD and OAC, formal and informal linkages to the mental health and chemical dependency treatment systems should be established, building upon existing relationships, and jointly advocating at the state level for more funding and targeted programs.
    - Coordination between the HOPWA and Ryan White CARE Act planning and funding bodies should assure optimal leveraging of resources and non-duplication of services.
    - Cross training opportunities should be established so that front-line workers in the AIDS housing and support, mental health services, and chemical dependency treatment systems can better respond to the range of issues that multiply-diagnosed people living with HIV/AIDS face and understand the capabilities and limitations of each system to respond to the multiple needs of its clients.

Strategies for Increasing Funding and Support for HIV/AIDS Housing and Supportive Services

The majority of people contacted through the process of assessing the need for HIV/AIDS housing in San Diego County identified "increasing funding and support for HIV/AIDS housing and supportive services" as a key strategy for successfully housing people living with HIV/AIDS. In this era of fierce competition for limited funding, it is incumbent upon consumers, community leaders and interested parties of all kinds to become knowledgeable about HIV/AIDS issues in San Diego County and to help ensure the viability and support of community-based efforts to meet the needs of people living with HIV/AIDS.

28. Implement a community-wide educational program that provides valuable information about the epidemic, its trends, and the services available to people living with HIV/AIDS.

29. Encourage community members and leaders throughout San Diego County to embrace this Plan and take steps to engage others at appropriate levels of authority in city, county, state, and federal government to assist in implementing its recommendations.

    - Ensure better coordination and collaboration among the funding and service systems which deliver housing, medical care, social service benefits, mental health services, chemical dependency treatment, job training, and criminal justice.
    - Encourage the development of special needs and affordable housing and the provision of supportive services throughout the county so that appropriate housing and services may be available to consumers in communities where they currently reside.
    - Take steps at the local level to create incentives for developers to set aside units in new construction which can be subsidized sufficiently with HOPWA or other funds to assure long-term affordability for disabled and very low-income tenants.

30. Encourage the increase of public and private funding for the range of housing and support service programs that people living with HIV/AIDS in San Diego County can access. Local and national coalitions exist to coordinate messages and advocacy strategies.

    - The HCD, with community input and participation, should take the lead in assuring that consumers, providers, advocates, community leaders, and elected officials are kept informed as to the status of federal legislation and programs and that information is disseminated broadly and in a timely fashion.
    - County and city government, AIDS housing and service providers, and funders should all include the goals of maintaining and increasing AIDS housing resources in San Diego County as key messages in their policy-related efforts at both state and federal levels.

31. Work towards the implementation of rental programs and landlord-tenant provisions that are friendly to people living with HIV/AIDS. As the housing market continues to favor landlords in San Diego County, large increases in rent, large security deposits and rent down-payments, and increasingly stringent income requirements have become commonplace, squeezing low-income renters out of the housing market. It is imperative that the HIV/AIDS community, together with other groups representing low-income and similarly disenfranchised communities, encourage the development of tenant-friendly rental programs and flexible landlord-tenant provisions that will provide increased affordable housing opportunities for persons living with HIV/AIDS. The HCD, OAC, the County HIV Housing Committee, the HIV Health Services Planning Council, HIV/AIDS housing and service providers, and consumers should work for the following:

    - Development and implementation of a damage deposit and rent guarantee program to provide a bail-out to landlords if a tenant defaults on paying rent.

Action Plan for HOPWA Cycle VIII

The following recommendations have been developed based on the findings of the needs assessment. The *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee has determined that it is vital for these recommendations to be initiated during the eighth cycle (2000-2001) of San Diego County Department of Housing and Community Development's Housing Opportunities for Persons With AIDS (HOPWA) program.

The following recommendations were developed based on data from the needs assessment process, including consumer, provider, and case manager surveys; Steering Committee and public meetings; one-on-one interviews with key housing and service providers; and consumer focus groups.

At the June 1999 meeting of the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee, recommendations were reviewed and the following recommendations were selected to be the first "action" steps. Given the dynamic nature of HIV disease and the uncertainty of future federal funding, the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs must be revisited regularly. Therefore, Action Plans will be developed on an annual basis.

Housing-Related Strategies

Recommendation:

Prioritize flexibility in funding HIV/AIDS housing activities. After setting priorities for new unit creation in its annual Request for Proposals for HOPWA funding, the San Diego County Department of Housing and Community Development (HCD) should remain flexible as to the kind of activities that are allowable, e.g., AIDS-specific housing development, mixed-population housing development, set-asides in new or existing affordable/mainstream housing developments, master leasing, and other "nondevelopment' strategies.

Action Steps:

- **HCD staff should evaluate the short- and long-term cost-effectiveness and benefits of proposed strategies.**
- **Incorporate the outcomes of this planning process into the development of priorities for HOPWA funding.**

Recommendation:

Assure the creation of a continuum of housing and services to meet the needs of people living with HIV/AIDS at all points in the disease spectrum. This goal is the vision of the HCD and the *San Diego Countywide Strategic HIV/AIDS Housing Plan* Steering Committee and the mandate of the HIV Health Services Planning Council.

Action Step:

- **Develop and publicly present an official "continuum of HIV/AIDS housing," including definitions of each type of housing. Emphasize the importance of housing stability to each person living with HIV/AIDS, especially in his/her ability to access services and medical care.**

Recommendation:

Increase permanent independent housing. It is both the greatest single need in the county and the highest ranked housing preference among consumers.

Action Steps:

- **Ensure the creation of up to 30 permanent independent housing units.**

Recommendation:

Maintain existing tenant-based rental assistance programs and explore potential changes that may enable more effective targeting of resources based on levels of income and need.

Action Steps:

- **Explore the possibility of requesting a shallow rent subsidy waiver from HUD for long-term HOPWA rental assistance.**
- **Coordinate potential HOPWA shallow rent subsidy with existing programs, including Partial Assistance Rental Subsidy (PARS).**
- **Maintain homelessness prevention as the primary focus of shallow rent subsidies.**
- **Evaluate the impacts of establishing higher income ceilings, the targeting of shallow subsidies to those with incomes between 50 percent and 80 percent of area median income, and allowing for different levels of assistance as income fluctuates or to accommodate rent increases.**
- **Consider prioritizing deep subsidies for those at the lowest income levels and for families needing units with three or more bedrooms.**

Recommendation:

Maintain the existing Residential Care Facilities for the Chronically Ill (RCF-CI) in North County and encourage the development of a similar facility in central San Diego. Consumers, providers, advocates and planners all expressed a resounding endorsement of the ongoing need for the level of on-site care and supervision that the RCF-CI's provide. Further analysis is required in order to determine the optimal size and location for such a facility in San Diego, based on development and operational costs and siting issues.

Action Step:

- **Assure adequate funding for the existing Residential Care Facilities for the Chronically Ill (RCF-CI) in North County and encourage the development of a similar facility in central San Diego.**

System-Wide Strategies

Recommendation:

AIDS housing providers and advocates should expand and strengthen existing linkages to AIDS support, mental health service and chemical dependency treatment systems to ensure access to these systems for eligible consumers.

Action Steps:

- **Establish and/or improve formal and informal linkages, with the support of the HCD and the San Diego County Office of AIDS Coordination (OAC), to the mental health and chemical dependency treatment systems, building upon existing relationships, and jointly advocating at the state level for more funding and targeted programs.**
- **Establish quarterly meetings of the executive officers of the County HIV Housing Committee, HIV Health Services Planning Council, and the staffs of the HCD and OAC. These meetings should focus on improving linkages between housing programs and other supportive services, including case management, mental health, and chemical dependency services, and establishing standards of care.**
- **Coordination between the HOPWA and Ryan White CARE Act planning and funding bodies should be improved to help assure optimal leveraging of resources and non-duplication of services.**
- **Cross training opportunities should be established so that front-line workers in the HIV/AIDS housing and support, mental health services and chemical dependency treatment systems can better respond to the range of issues that multiply diagnosed people living with HIV/AIDS face, and understand the capabilities and limitations of each system to respond.**

Strategies for Increasing Funding and Support for HIV/AIDS Housing and Supportive Services

Recommendation:

Work towards the implementation of rental programs and landlord-tenant provisions that are friendly to people living with HIV/AIDS. As the housing market continues to favor landlords in San Diego County, large increases in rent, large security deposits and rent down-payments, and increasingly stringent income requirements have become commonplace, squeezing low-income renters out of the housing market. It is imperative that the HIV/AIDS community, together with other groups representing low-income and similarly disenfranchised communities, work for tenant-friendly rental programs and flexible landlord-tenant provisions that will provide increased affordable housing opportunities for persons living with HIV/AIDS.

Action Steps:

- **The HCD, OAC, County HIV Housing Committee, HIV Health Services Planning Council, HIV/AIDS housing and service providers, and consumers should work for the following:**
  - **Development and implementation of a damage deposit and rent guarantee program to provide a bail-out to landlords if a tenant defaults on paying rent**.

San Diego Countywide Strategic HIV/AIDS Housing Plan

Appendices

Appendix 1: Nondevelopment

Nondevelopment is a process of creating housing units without going through the development process. Strategies for nondevelopment include set-asides in other housing developments and lease buy-downs. Nondevelopment is an easy, faster, and less expensive process and requires no housing development expertise. Resulting housing units are dispersed and integrated with mainstream housing.

Nondevelopment: A Better Way to Create Housing for People with AIDS

For many years nonprofit housing development has been regarded as the best means to insure long-term affordable housing. As the need for AIDS housing has grown, many organizations have chosen housing development as a means to meet this need. Housing developments can offer affordability without the uncertainty of the Section 8 rental assistance program. However, the many drawbacks of housing development have led some to look for new ways to create affordable housing for people living with AIDS. Nondevelopment, or finding housing units without going though the whole housing development process, is an increasingly popular way of meeting AIDS housing needs.

Development Disadvantages

The disadvantages of developing housing for people living with AIDS can be enormous. Housing development can be a very time-consuming process. Developing housing for people with extremely low incomes requires significant public subsidy. Most public funders require housing developers to leverage their money with subsidies from other public funders. The requirements of different public funders can be complex, confusing, and even contradictory. To navigate this public funding system, organizations must either allocate substantial staff time to the project or hire expensive consultants (or both). For organizations whose mission is to serve people living with AIDS, this can involve diverting scarce resources away from their primary activities. Furthermore, most funding is allocated competitively, and there are no guarantees that the investment of time and resources will generate the desired housing.

The development process is only the beginning of the resources drain. Once housing is successfully developed, the tenants and property must be managed. Many organizations have discovered that addressing the operational issues is more challenging than was the development process. Learning housing management can be a difficult and draining process. Furthermore, there are few management companies willing to take on a contract for the fees most projects serving extremely low-income can afford.

Perhaps the most important drawback in developing housing is the effect it has on people living with AIDS. By choosing a long, drawn-out development process over faster options, organizations produce housing slowly, and homeless or ill-housed people living with AIDS must wait longer to for decent housing. In an ever-changing environment for people living with

AIDS, housing that takes two or three years to develop may no longer be appropriate to their needs when it eventually opens. Finally, most AIDS housing development produces AIDS-specific housing facilities. However, consumer preference studies conducted across the country show that the vast majority of people living with AIDS prefer living in regular independent units that are not a part of larger AIDS housing complexes. It is very difficult to efficiently offer this kind of housing as an AIDS housing developer.

Choosing the Nondevelopment Option

One can avoid all of these pitfalls by choosing nondevelopment. Nondevelopment is the creative production of long-term affordable housing units for people living with AIDS without going through a long housing development process. Nondevelopment is when mainstream housing providers include units for people living with AIDS in their housing developments. It lets others with experience and expertise wrangle through the public funding process while securing some of the benefits of their labors for people living with AIDS. Through nondevelopment one can often create units in a fraction of the time and effort it takes with housing development.

How to Nondevelop

The key to a successful nondevelopment project is finding an interested housing partner. A housing partner could be any company that provides affordable housing in your community: for-profit developers, housing nonprofits, and housing authorities. Your challenge is to encourage a potential housing partner to set aside units for people living with AIDS and to rent them at levels affordable to extremely low-income people. Since these rents may be much lower than what even affordable housing providers offer, you may need to provide housing partners with more than just the opportunity to serve a needy population.

You can offer a number of possible benefits to a potential housing partner:

- coordinated service delivery to people living with AIDS;
- increased competitiveness of public funding proposals; and/or
- cash.

When approaching potential housing partners, the most important thing you can bring to the table is a thorough understanding of the supportive service needs of people living with AIDS and a well-developed plan for addressing these needs. The best way to learn about the service needs of people living with AIDS in your community is to talk with them and to talk with other providers of housing. If your community does not have existing AIDS housing providers, research projects in other similar communities. The next step is to discover the resources available in your community to address those needs identified. Prior to ever meeting with a housing partner you should have already developed formal linkages with all necessary service providers. You will need to persuade the housing partners that providing housing to people living with AIDS will put no additional burden on their housing projects and that systems are in place to deal with their day-to-day and emergency needs.

Some communities already have mainstream housing developers that provide housing for people with extremely low incomes. People living with AIDS may represent a portion of the target population of their housing projects. If the housing providers are already offering units affordable to the people you want to house, the well-thought-out service plan may be all you need to secure some units in their developments. They might very well welcome the partnership.

One of the best ways to secure nondevelopment units is to work with housing developers who are proposing large, new publicly-funded housing developments. A set-aside of a few units for extremely low-income people living with AIDS might have a minimal impact on the financial projections for a very large project, yet it could greatly increase the fundability of such a project. Many public funders offer competitive advantages to projects that include set-asides for people with special needs. For example, the Washington State Housing Finance Commission offers ten points in its tax credit allocation plan to projects that include a 20 percent unit set-aside for people with special needs. In a very competitive year, this could mean the difference between a project receiving a tax credit allocation and not. The well-developed service plan is an important component in marketing yourself to these housing developers.

If you have tried the above methods and still have no housing set-asides for people living with AIDS, you have one more thing to offer: cash. As an AIDS housing provider, you have access to Housing Opportunities for Persons With AIDS (HOPWA) funds. HOPWA funds can be used in a variety of ways to court a housing partner. A direct infusion of HOPWA dollars into a new housing development may allow a housing developer to set-aside some units with very low rents affordable to extremely low-income people living with AIDS. The HOPWA money could be used to capitalize an operating reserve for those units or to reduce the amount of expensive debt the developer would otherwise have to incur.

If you want more control over the units, a lease buy-down may be the nondevelopment option. In this scenario, you pay the housing partner a substantial front-end lease payment (perhaps HOPWA-funded) in exchange for lower rents over time. For example, your lease payment may buy down rents from an affordability level of 50 percent of median income down to levels affordable to an SSI household. The front-end payment is invested by the housing partner and drawn down to cover the difference in rental income streams over time. The actual amount of the front-end payment is negotiated and can be quite high, depending on the original affordability level of the units, the desired affordability level, the length of the lease, the operating costs and debt service of the development, interest rates, and how willing your partner is to work with you. AIDS Housing of Washington has examples of fifty-year lease buy-down agreements negotiated with local housing providers and approved by public lenders. One major advantage to this arrangement is that lease buy-downs can be negotiated for existing projects, thus avoiding the long development period.

If your community has experienced affordable housing providers, you should seriously consider a nondevelopment option before embarking on an expensive new AIDS housing development. Nondevelopment allows the housing development experts do the housing development and AIDS housing providers to reap the benefits. Nondevelopment can mean securing units for people living with AIDS faster, cheaper and more easily.

Appendix 2: Survey Tools

HIV/AIDS Housing Consumer Survey

This is a housing needs survey for people who have HIV/AIDS. Your participation is very important, and we would like to have your input. The information gathered in this survey will be used to develop the Strategic HIV/AIDS Housing Plan for addressing the housing needs of people living with HIV/AIDS who reside in San Diego County. ***Your answers are completely confidential****. If you need assistance to complete this survey, please talk with the person who gave it to you. Thank you for your participation.*

Si prefiere contestar esta repuestas in espanol, por favor discretir con la persona quien se lo dio.

---

1. Have you completed this survey before?

[ ] Yes ➔ ***If yes, please do not fill out this form again!***
[ ] No

The first part of the survey is about you (questions 2-11). Remember, all answers will remain confidential. These questions will help make sure that we are reaching a wide variety of people and that our plan reflects the community of people living with HIV and AIDS.

2. Have you been infected with HIV, the virus that causes AIDS?

[ ] Yes ➔ If yes, what is your current HIV status? ***Check only one answer.***

[ ] 'Asymptomatic' HIV - no physical problems (no AIDS diagnosis).

➔ What year did you learn of your HIV status? _____

[ ] 'Symptomatic' HIV - some physical problems (no AIDS diagnosis).

➔ What year did you learn of your HIV status? _____

[ ] AIDS diagnosis asymptomatic - I have been told I have AIDS but have no physical problems.

➔ What year did you learn of your AIDS diagnosis? _____ HIV diagnosis?_____

[ ] AIDS diagnosis symptomatic - I have been told I have AIDS and have physical problems.

➔ What year did you learn of your AIDS diagnosis? _____ HIV diagnosis?_____

[ ] No, I am HIV negative. ***Please do not continue completing this survey!***

3. What is your gender?

[ ] Female
[ ] Male
[ ] Transgender
[ ] Other:_____

4. What is your sexual orientation?

[ ] Woman who has sex only with other women (including Lesbian)
[ ] Man who has sex only with other men (including Gay/Homosexual)
[ ] Woman or man who has sex with people of same and opposite gender (Bisexual)
[ ] Woman or man who has sex only with people of opposite gender (Straight/Heterosexual)

5. What year were you born? _____

6. What is your racial/ethnic group(s)? ***Check the group that best applies.***

[ ] Caucasian/white (non-Hispanic)
[ ] Hispanic/Latino/a
[ ] African American
[ ] Southeast Asian
[ ] Other Asian
[ ] Pacific Islander
[ ] Native American /Alaska Native

[ ] Multiracial _____ [ ] Other racial/ethnic group: _____

7. Is your primary language English?

[ ] Yes

[ ] No ➔ If no, please specify your primary language _____

8. Are you disabled by HIV/AIDS?

[ ] Yes

[ ] No

9. Do you have a disability other than HIV/AIDS? ***Check all that apply***

[ ] Physical disability
[ ] Blind
[ ] Deaf/Hard of hearing
[ ] Mental illness
[ ] Chemical dependency
[ ] Developmental disability

[ ] Other _____

10. What do you believe put you at risk for HIV infection? ***Check all that apply***

[ ] Sexual activity
[ ] Sharing needles/equipment
[ ] Tainted blood products/hemophilia

[ ] Other _____

11. Have you ever been in jail, county lock-up, or prison?

[ ] Yes ➔ If yes, for how long _____

[ ] No

Questions 12-19 are about your current housing situation.

12. Who do you live with? ***Check only one answer***

[ ] Live alone ➔ *skip to #13*

[ ] Spouse/partner
[ ] Spouse/partner and children
[ ] Your children and no other adults
[ ] Parent(s)/family
[ ] Friend(s)/roommate(s)
[ ] Other _____

12a. How many people live with you?

Total number, including yourself: _____
How many adults (aged 18 and older)? _____
How many children (aged 17 or younger)? _____

12b. Is there another person(s) living with you who is HIV-positive or has AIDS?

[ ] Yes ➔ What is your relationship with this person (s)? _____

[ ] No

13. In what city do you live?_____ What is your zip code? _____

14. Have you ever experienced discrimination in getting housing, or been denied housing, for the following reasons?

[ ] Yes ➔ ***Please check all reasons that apply***

[ ] Race/ethnicity
[ ] HIV/AIDS
[ ] Gay/lesbian
[ ] Children/family size
[ ] Criminal history/prison record
[ ] Poor credit rating

[ ] Other _____

[ ] No

15. Today, what kind of a place do you live in? ***Check only one answer***

[ ] Homeless, on the streets or in a car, in a vacant building or 'cathole'
[ ] In a shelter
[ ] In a hotel or motel
[ ] Stay for free or 'crashing' with friends or relatives
[ ] In a drug or alcohol treatment center
[ ] In a halfway house
[ ] HIV/AIDS housing facility or building
[ ] Rent a room in a house
[ ] Rent a house, apartment, condo or mobile home
[ ] Own a house, apartment, condo or mobile home
[ ] Hospital or skilled nursing facility

[ ] Other (please explain) _____

16. How long have you lived where you are now? ***Check only one answer***

[ ] Less than 1 month
[ ] 1 month to 6 months
[ ] 6 months to 12 months
[ ] 1 to 2 years
[ ] 3 to 5 years
[ ] More than 5 years
[ ] All your life

17. Was having HIV/AIDS a reason you were able to get the housing you have now?

[ ] Yes
[ ] No

18. Are you getting rental assistance?

[ ] Yes ➔ **If yes, what kind(s)?**
[ ] Section 8 housing (tenant-based certificate)
[ ] Shelter Plus Care
[ ] HOPWA/TBRA
[ ] PARS
[ ] Other_____

[ ] No

19. Are you on any waiting lists for housing or rental assistance?

[ ] Yes ➔ **If yes, do you know which one(s)? If so please check.**
[ ] Shelter Plus Care - how long? _____
[ ] Section 8 - how long? _____
[ ] HOPWA/TBRA - how long? _____
[ ] Other waiting list - how long? _____
[ ] Not sure which one

[ ] No

*Questions 20-25 are about your **household** income. By household we mean all the people who live with you.*

20. Do you receive any of the following benefits? ***Check all that apply***

[ ] GR (General Relief)
[ ] SSI (Supplemental Security Income)
[ ] SSA/SSDI (Social Security Disability Income)
[ ] TANF (formerly AFDC - Aid to Families with Dependent Children)
[ ] Food stamps
[ ] Veteran's benefits or retirement
[ ] MediCal/Cal-Optima
[ ] Medicare
[ ] Waiver services (HIV/AIDS Home and Community Services)
[ ] Private health insurance
[ ] Private disability insurance
[ ] ADAP (Drug Assistance Program)

21. Do your income and benefits support people other than yourself?

[ ] Yes ➔ *continue*
[ ] No ➔ *skip to #22*

21a. If yes, who do they support? ***Check all that apply***

[ ] My minor children
[ ] My adult children
[ ] My grandchildren
[ ] My parents
[ ] My partner / spouse

[ ] Other _____

22. What are your monthly cash (out-of-pocket) costs for health care, including prescriptions, for you and the people you support? $_____

23. What is your monthly household income (combined income of everyone living with you)? _____

23a. How much of that amount is earned through work? $_____

24. What is your share of your monthly rent or mortgage? $_____

24a. In addition to your rent, how much more do you spend on average for utilities such as heat, electricity, gas, and water, NOT including telephone and cable TV? $_____

25. Would you have to move if your rent or mortgage payment went up by about $50?

[ ] Yes
[ ] No

Questions 26-28 have to do with changes you may have had in your housing since you learned about your HIV status. Remember, these are only changes since learning that you were HIV infected.

26. Have you ever had to do any of these things to have a place to sleep since you found out about your HIV status? ***Check all that apply***

[ ] Slept in a car
[ ] Traded sex for a place to spend the night, or money for rent
[ ] Slept in a shelter
[ ] Slept at a friend's house
[ ] Slept on the streets, in a park, or other outdoor place:_____
[ ] None of these

27. Have you had to move since you learned you have HIV/AIDS?

[ ] Yes ➔ *continue*
[ ] No ➔ *skip to # 28*

27a. If yes, what were the reasons for your move? ***Check all that apply***

[ ] I was asked to move because I am HIV-positive
[ ] I was asked to move because of my drug/alcohol use
[ ] I was evicted
[ ] I moved because I was released from jail or prison
[ ] I moved because I couldn't live independently anymore
[ ] I moved because I no longer had enough money to pay my rent
[ ] I moved for financial or physical support from a caregiver (family or friends)
[ ] I moved to live with/near family
[ ] I moved to a place I liked better
[ ] I moved to be in a safer neighborhood
[ ] I moved to get away from my old neighborhood
[ ] I moved so that I could remain clean and sober
[ ] I moved to find a job
[ ] I moved to get better HIV/AIDS-related services (including doctor)
[ ] I moved to be closer to HIV/AIDS-related services (including doctor)
[ ] Other _____

27b. How many times have you moved in the past 3 years? _____ In the past 12 month _____

28. Have you ever been homeless? By this we mean without a regular place to stay the night.

[ ] Yes ➔ *continue*
[ ] No ➔ *skip to # 29*

28a. How many times have you been homeless *in the last three years?*_____

28b. How long was your most recent period of homelessness?

[ ] a few days to a week
[ ] a few weeks to a month
[ ] two months to a year
[ ] more than a year

28c. Why did you become homeless the last time? ***Check all that apply***

[ ] Evicted
[ ] Loss of income (from job or benefits)
[ ] Family/partner/roommate made me move
[ ] Substandard unit or condemned building
[ ] Newly arrived in area and had no resources
[ ] Released from jail, county lock-up or prison
[ ] Other:_____

Questions 29-31 have to do with your use of drugs and alcohol.

29. Are you currently active in a drug or alcohol treatment or recovery program?

[ ] Yes ➔ *continue*
[ ] No ➔ *skip to # 30*

29a. What kind of treatment program? ***Check all that apply***

[ ] Methadone maintenance program
[ ] Drug-free outpatient counseling program
[ ] 12-step program (AA, NA, CA)
[ ] Residential rehabilitation program
[ ] Inpatient detox program

[ ] Other: _____

30. What substances/drugs do you use now? ***Check all that apply***

[ ] I only take prescription medications ➔ *skip to # 31*

[ ] Alcohol ➔ how many times a week? _____

[ ] Marijuana ➔ how many times a week? _____

[ ] Crack ➔ how many times a week? _____

[ ] Cocaine ➔ how many times a week? _____ ➔ how do you use cocaine? _____

[ ] Heroin ➔ how many times a week? _____ ➔ how do you use heroin? _____

[ ] Methamphetamine/speed ➔ how many times a week? _____
➔ how do you use methamphetamine?_____

[ ] Pills not prescribed for me by my doctor ➔ which ones? _____

[ ] Other:_____

31. If you want or need alcohol or drug treatment now and are not getting it, please tell us why.

Check all that apply

[ ] I don't want treatment right now
[ ] No beds are available
[ ] I don't know where or who to call for help
[ ] I am on a waiting list for a methadone program
[ ] I am on a waiting list for a treatment program (not methadone)
[ ] I was in a program but was asked to leave
[ ] Cost of treatment is too high/not covered by insurance
[ ] Location of treatment program
[ ] Lack of child care
[ ] Other:_____

Questions 32-36 are about the types of services that you need and/or are accessing.

32. Have you ever received treatment for a mental illness?

[ ] Yes
[ ] No

33. Are you currently receiving counseling, therapy, or some other type of mental health services?

[ ] Yes ➔ **If yes, what kind of services?** ***Check all that apply.***

[ ] Counseling and/or therapy
[ ] Medication treatment
[ ] Other – please specify: _____

[ ] No

34. If you want or need mental health services now and are not getting them, please tell us why.

Check all that apply

[ ] I don't want treatment right now
[ ] No beds are available
[ ] I don't know where or who to call for help
[ ] I am on a waiting list for mental health services
[ ] I was in a mental health program but was asked to leave
[ ] Cost of mental health services is too high/not covered by insurance
[ ] Location of mental health program
[ ] Lack of child care

[ ] Other:_____

35. Are you currently receiving any other supportive services?

[ ] Yes ➔ **What other supportive services are you currently receiving? *Check all that apply.***

[ ] Assistance with daily activities
[ ] Assisted transportation
[ ] Benefits counseling
[ ] Case management
[ ] Child care
[ ] Dental care
[ ] Education/literacy program services
[ ] Emergency drug assistance
[ ] Emergency financial assistance
[ ] Food bank
[ ] Home-delivered meals
[ ] Homemaker services
[ ] Interpreter services
[ ] Legal services
[ ] Life skills training
[ ] Nutrition counseling
[ ] Primary medical care
[ ] Professional home health care
[ ] Respite care
[ ] Vocational rehabilitation/employ. services
[ ] Other – please specify: _____

[ ] No

36. Are there other supportive services that you want or need that you are not currently receiving?

[ ] Yes ➔ **What other supportive services do you need or want to receive? *Check all that apply***

[ ] Assistance with daily activities
[ ] Assisted transportation
[ ] Benefits counseling
[ ] Case management
[ ] Child care
[ ] Dental care
[ ] Education/literacy program services
[ ] Emergency drug assistance
[ ] Emergency financial assistance
[ ] Food bank
[ ] Home-delivered meals
[ ] Homemaker services
[ ] Interpreter services
[ ] Legal services
[ ] Life skills training
[ ] Nutrition counseling
[ ] Primary medical care
[ ] Professional home health care
[ ] Respite care
[ ] Vocational rehabilitation/employ. services
[ ] Other – please specify: _____

[ ] No

Questions 37-42 are about the types of housing that are available to persons with HIV/AIDS, and your thoughts about them. For each, you will be asked to rank the types by your needs or preference. Put a "1" next to the choice you like best, a "2" next to your second choice, etc. Please do not just put check marks!

37. Based on your current health, would you choose to:

[ ] Stay where you are ➔ *skip to # 38*

[ ] Move ➔ *continue*

37a. If you would like to move, what kind of housing situation would you choose now? Rank in order of choice, "1" = first choice, to "7" = last choice – please don't just put check marks.

a. __Move to live alone
b. __Move to parents or extended family
c. __Live with friends or roommate
d. __Live in a shared house/apartment with other people who have HIV/AIDS
e. __Move to a housing program with supportive services on-site, i.e. meals, attendant care
f. __Hospice care facility
g. __Skilled nursing facility (24-hour nursing care)

38. If you get sicker from HIV or AIDS, would you choose to:

[ ] Stay where you are ➔ *skip to # 39*

[ ] Move ➔ *continue*

38a. If you would like to move if you get sicker, what kind of housing situation would you choose?

Rank in order of choice, "1" = first choice, to "7" = last choice - please don't just put check marks.

a. __Move to live alone
b. __Move to parents or extended family
c. __Live with friends or roommate
d. __Live in a shared house/apartment with other people who have HIV/AIDS
e. __Move to a housing program with supportive services on-site, i.e., meals, attendant care
f. __Hospice care facility
g. __Skilled nursing facility (24-hour nursing care)

39. If you had to move, what is most important about the neighborhood where you might live?

Rank in order of choice, "1" = first choice, to "6" = last choice

a. __Living close to shopping areas
b. __Living close to your doctor, clinic, or hospital
c. __Living close to friends or family
d. __Living close to public transportation
e. __Living close to a child care or day care center
f. __Living close to your job

40. If you had to move, what is the most important quality about your home?

Rank in order of choice, "1" = first choice, to "5" = last choice

a. __Living with people of your same cultural group and language (which group or language?_____)
b. __Living in a safe neighborhood
c. __Living in a building where drug and alcohol use is tolerated
d. __Living in a wheelchair-accessible building
e. __Living in clean and sober housing

41. How would you feel about living in an apartment building which is designed to house a mix of people including people with mental illness, people with substance abuse problems and people with HIV/AIDS?

[ ] Like - why?_____

[ ] Don't care – why?_____

[ ] Dislike - why?_____

42. Based on your current income, if you had to choose between <u>each</u> of the following options, which would you prefer? ***Please check one box under each option below***

Option #1

[ ] Pay more rent to have my own place

OR

[ ] Share a less-expensive apartment or house with others

Option #2

[ ] Move to another city for a less-expensive place of my own

OR

[ ] Live close to my current neighborhood in shared housing

Option #3

[ ] Live in an apartment building where only other people with HIV/AIDS live

OR

[ ] Live in an apartment building that mixes people with HIV/AIDS with other residents

43. Are you currently taking protease inhibitors?

[ ] Yes ➔ **If you are taking protease inhibitors:**

For how long have you been taking them: _____

How would you rate your overall health since starting protease inhibitors?

[ ] Better [ ] About the same [ ] Worse

Are you currently working? [ ] Yes [ ] No If no:

Are you making plans to go back to work? [ ] Yes [ ] No

Have you moved or are you thinking of moving because you are feeling better?

[ ] Yes ➔ If yes, please explain_____

[ ] No

[ ] No ➔ **If you are <u>not</u> taking protease inhibitors please indicate why:**

[ ] My doctor hasn't recommended them

[ ] I tried but could not tolerate them, or there were too many side effects

[ ] I started them, but could not comply with the regimen

[ ] I can't access them/have no funding

[ ] Don't want to at this time

[ ] Other _____

44. Do you have anything to add, or is there something we missed?

_____

_____

_____

_____

Housing Provider and AIDS Service Organization Survey

Note: This questionnaire is part of a comprehensive countywide needs assessment for housing needs of people who have HIV/AIDS. Your participation is very important and we would like to have your input. The information gathered in this needs assessment will be used in the development of the San Diego Countywide Strategic HIV/AIDS Housing Plan. Thank you.

1. What are the primary services your agency provides to people living with HIV/AIDS?

_____

_____

_____

2. What percentage of your agency's total program services are for persons living with HIV/AIDS? _____
What percentage of your housing services? _____

How many HIV/AIDS clients of your agency received housing services in 1998? _____

Please indicate whether numbers are: [ ] best guess estimate or [ ] actual client counts

3. First, please indicate which of the following housing services your agency provides directly (mark all that apply).

Then, please rank the ones you provide by relative volume of service for your HIV/AIDS clients. ("1" = most utilized service, "11" = least utilized service)

Check Provided	**Rank Volume**	
[ ]	a. _____	No housing programs
[ ]	b. _____	Housing information or referral
[ ]	c. _____	Housing advocacy
[ ]	d. _____	Emergency financial assistance (deposits, utilities, rent, etc.)
[ ]	e. _____	PARS
[ ]	f. _____	HOPWA/TBRA
[ ]	g. _____	Section 8 housing (received, not just placed on waiting list)
[ ]	h. _____	Residential drug/alcohol treatment
[ ]	I. _____	Residential mental health or developmental disability programs
[ ]	j. _____	HIV/AIDS specific housing program, which one(s)? _____
[ ]	k. _____	Other housing, describe _____

4. Please rank the following housing options as to which are most needed by your agency's clients. ("1" = most needed, to "11" = least needed)

a._____ Homeless shelter
b._____ Emergency/short-term financial assistance for rent and utilities
c._____ Transitional housing (up to six months with life skills/job skills training)
d._____ Shared houses/apartments with little or no on-site support services
e._____ Subsidized independent living in an apartment with no on-site services
f. _____ Long-term rental assistance to keep people in their own home
g._____ Shared houses/apartments with some on-site support services
h._____ Housing program that tolerates drug/alcohol use off-premises
i. _____ Clean and sober housing program
j. _____ Residential hospice
k._____ Skilled nursing facility

5. Please indicate what you think are the greatest barriers your agency's clients face in receiving housing assistance (mark all that apply).

[ ] Language
[ ] Providers don't know what's available or how to access
[ ] Clients don't know what's available or how to access
[ ] Application process is too difficult
[ ] Location of services
[ ] Lack of client motivation
[ ] Not enough appropriate housing options
[ ] Rental assistance isn't enough to get a decent place
[ ] Not enough clean and sober housing programs
[ ] Not enough drug/alcohol tolerant programs
[ ] Not enough options for families with children

[ ] Other _____

6. For the clients of your agency who have INDEPENDENT housing (either in subsidized housing or on their own), please answer the following two-part question.

First, please rank them in order of importance for maintaining independent housing. (1 = most important, 11 = least important)

Then, please mark the ones your independently housed clients need but are not getting (mark all that apply).

Rank Importance	**Check Unmet Need**
a. _____	[ ] Practical/chore service support
b. _____	[ ] Meals/nutrition counseling
c. _____	[ ] Protective payee/money management
d. _____	[ ] Personal care/personal hygiene assistance
e. _____	[ ] Alcohol/drug treatment/counseling
f. _____	[ ] Day mental health program
g. _____	[ ] Emotional support/buddy
h._____	[ ] Transportation assistance
I. _____	[ ] Benefits counseling
j. _____	[ ] Home health care
k._____	[ ] Other support service_____

7. If you were to change or expand your agency's housing services, what would you do?

_____

_____

_____

8. What else would you like to share with us regarding the housing needs or the housing system for persons living with HIV/AIDS in San Diego County?

_____

_____

_____

HIV/AIDS Case Manager Survey

1. Please rank the following housing options as to which are most needed by your clients.

("1" = most needed, to "11" = least needed)

a._____ Homeless shelter
b._____ Emergency/short-term financial assistance for rent and utilities
c._____ Transitional housing (6 - 24 months with life skills/job skills training)
d._____ Shared houses/apartments with little or no on-site support services
e._____ Subsidized independent living in an apartment with no on-site services
f. _____ Long-term rental/mortgage assistance to keep people in their own home
g._____ Shared houses/apartments with some on-site support services
h._____ Housing program that tolerates drug/alcohol use off-premises
i. _____ Clean and sober housing program
j. _____ Residential hospice
k._____ Skilled nursing facility

2. Please indicate what you think are the greatest barriers your clients face in receiving housing assistance (mark all that apply).

[ ] Language
[ ] Providers don't know what's available or how to access
[ ] Clients don't know what's available or how to access
[ ] Application process is too difficult
[ ] Location of services
[ ] Lack of client motivation
[ ] Not enough appropriate housing options
[ ] Rental assistance isn't enough to get a decent place
[ ] Not enough clean and sober housing programs
[ ] Not enough drug/alcohol tolerant programs
[ ] Not enough options for families with children
[ ] Other _____

3. For the clients that you see who have INDEPENDENT housing (either in subsidized housing or on their own), please answer the following two-part question.

First, please rank them in order of importance for maintaining independent housing. (1 = most important, 11 = least important)

Then, please mark services your independently housed clients need but are not getting (mark all that apply).

Rank Importance	**Check Unmet Need**
a. _____	[ ] Practical/chore service support
b. _____	[ ] Meals/nutrition counseling
c. _____	[ ] Protective payee/money management
d. _____	[ ] Personal care/personal hygiene assistance
e. _____	[ ] Alcohol/drug treatment/counseling
f. _____	[ ] Day mental health program
g. _____	[ ] Emotional support/buddy
h._____	[ ] Transportation assistance
I. _____	[ ] Benefits counseling
j. _____	[ ] Home health care
k._____	[ ] Other support service_____

4. How many of your HIV/AIDS clients received housing services in 1998? _____

5. Please answer the following two-part question regarding housing services.

First, please indicate which ones your clients access (mark all that apply).

Then, please rank them in order of utilization. (1 = most used, 10 = least used)

Check Access	**Rank Utilization**	
[ ]	a. _____	Housing information or referral
[ ]	b. _____	Housing advocacy
[ ]	c. _____	Emergency financial assistance (deposits, utilities, rent, etc.)
[ ]	d. _____	PARS
[ ]	e. _____	HOPWA/TBRA
[ ]	f. _____	Section 8 housing
[ ]	g. _____	Residential drug/alcohol treatment
[ ]	h. _____	Residential mental health or developmental disability programs
[ ]	i. _____	HIV/AIDS specific housing program, which one(s)? _____
[ ]	j. _____	EARP Pool
[ ]	k. _____	Other housing, describe _____

6. If you were to suggest changes or expansions to another agency's housing services, what would you like to see them do?

_____

_____

_____

7. What else would you like to share with us regarding the housing needs or the housing system for persons living with HIV/AIDS in San Diego?

_____

_____

_____

_____

_____

_____

Appendix 3: Vacancy Rates

Table A-1
1990 Actual and 1998 Estimated Vacancy Rates, by Percent and San Diego County Community

Jurisdiction	Percent Vacant 1990	Percent Vacant 1998
Carlsbad	8.2	1.3
Chula Vista	4.1	4.9
Coronado	19.9	13.0
Del Mar	11.5	3.8
El Cajon	4.5	3.0
Encinitas	6.1	0.7
Escondido	6.6	2.2
Imperial Beach	4.7	1.9
La Mesa	3.9	2.2
Lemon Grove	2.9	4.0
National City	3.1	9.9
Oceanside	8.5	2.5
Poway	3.5	3.5
San Diego	5.9	3.5
San Marcos	5.9	1.6
Santee	2.8	3.0
Solana Beach	13.4	0.0
Vista	7.5	6.0
Unincorporated	7.2	3.3
Regional Total	**6.2**	**3.9**

Source: San Diego Association of Governments, *Draft Regional Housing Needs Statement, San Diego Region,* November 1998.

Appendix 4: Glossary

This glossary of terms is included for the reference of the reader.

AFFORDABLE HOUSING Housing is generally defined by the U.S. Department of Housing and Urban Development (HUD) as affordable when the occupant is paying no more than 30 percent of their adjusted gross income for housing costs, including utilities. Affordability is defined as a percentage of household income compared to the area average median income. Housing is typically considered "affordable" for households with incomes up to 80 percent of the average median income.

AIDS Acquired Immunodeficiency Syndrome. A disorder of the immune system that limits the body's response to certain infections and cancers. It can cause different illnesses in different individuals.

ALCOHOL/OTHER DRUG ADDICTION A serious and persistent alcohol or other drug use habit that significantly limits a person's ability to live independently.

ASSISTED HOUSING Owner-occupied or rental housing which is subject to restrictions on rents, rate of return, or sale price as a result of one or more governmental subsidies including grants, loans, or rent subsidies from public funds; housing bonus, transferable development rights programs, or mitigation funds administered by the city; or tenant-based subsidies such as certificates or vouchers.

ASSISTED LIVING Assisted living facilities are group residences that offer the delivery of professionally managed personal and health care services, including meals, 24-hour attendant care, social activities, assistance with bathing, dressing and transferring, dispensing medication, and health monitoring. Assisted living is intended for those who need some assistance in performing the activities of daily living but who do not need the heavy medical supervision provided by a skilled nursing facility. Assisted living facilities may be HIV/AIDS-specific, or they may serve many needs.

ASYMPTOMATIC Without symptoms. Describing a person who is HIV-positive, but who is not sick and who shows no clinical symptoms of the disease.

AT RISK OF BECOMING HOMELESS Being on the brink of becoming homeless due to inadequate income or paying too high a percentage of income on rent (typically 50 percent or more).

BEDS The unit of measure when describing the housing capacity or availability for skilled nursing facilities, hospices, board and care, adult family living, assisted living, and other such facilities.

CASE MANAGEMENT The central component of HIV/AIDS care is case management. Essentially, case managers coordinate all the care a client receives from all providers in the community. Typically, case management services are provided by agencies separate from the housing

providers. When a case management client resides in a residence, however, the residential staff members have the most frequent contact with the resident and often take on the care coordination.

CHEMICAL DEPENDENCY Addiction to drugs and/or alcohol.

CMI Pertaining to a person with chronic mental illness.

CONSOLIDATED PLAN Document submitted annually to HUD that serves as the planning document of the jurisdiction and an application for funding under any of the community planning development formula grant programs (CDBG, ESG, HOME, HOPWA).

CONTINUUM OF CARE An approach that helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning, application, and reporting documents for HUD's Shelter Plus Care, Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO), and Supportive Housing Programs.

COST BURDEN The extent to which gross housing costs, including utility costs, exceed 30 percent of gross income, based on data published by the U.S. Census Bureau.

COST BURDEN, SEVERE The extent to which gross housing costs, including utility costs, exceed 50 percent of gross income, based on data published by the U.S. Census Bureau.

DEVELOPMENTAL DISABILITY Referring to a variety of disabilities which impact cognitive functioning and learning style. Sometimes referred to as mentally retarded.

DISABLED HOUSEHOLD A household composed of one or more persons, at least one of whom is an adult (a person of at least 18 years of age) who has a disability. (See also glossary definition for "Person with a Disability.")

DISCRIMINATION Treating a person differently because they belong to, or are perceived to belong to, an identifiable group. Often discrimination is due to a person's being from a different race, country, religion, or because they're female, have a family, are older, disabled, or are gay or lesbian.

EMA/EMSA Eligible Metropolitan (Statistical) Area. Geographic areas designated by population and cumulative AIDS cases to receive federal funds through the Ryan White CARE Act and Housing Opportunities for Persons with AIDS (HOPWA) Program.

EMERGENCY HOUSING ASSISTANCE One-time or very short-term assistance provided to address an immediate housing crisis—often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis; the assistance is usually one of the following: emergency rent, mortgage or utility payments to prevent loss of residence, motel vouchers; and/or emergency shelter.

EMERGENCY SHELTER Any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of the homeless.

EXTREMELY LOW-INCOME An individual or family whose income is between 0 and 30 percent of the median income for the area, as determined by HUD.

FAIR HOUSING ACT The federal Fair Housing Act prohibits, among other things, the owners of rental housing from discriminating against potential tenants based on race, sex, national origin, disability, or family size.

FAIR MARKET RENT (FMR) Rents set by HUD for a state, county, or urban area that defines maximum allowable rents in subsidy programs.

FAMILY For the purposes of HUD documentation of households and census data compilations, the term "family" is often more accurately descriptive of a "household comprised of related individuals." For example: a family is a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

For purposes of the Plan and local policy interpretation, the term "family" encompasses non-traditional households, including families made up of unmarried domestic partners. A family is a self-defined group of people who may live together on a regular basis and who have a close, long-term, committed relationship, and share responsibility for the common necessities of life. Family members may include adult partners, dependent elders, or children, as well as people related by blood or marriage.

GROUP HOUSING/SHARED LIVING Two or more single adults, or families with children, sharing living arrangements in a house or an apartment. Generally, individuals each have a bedroom and share a kitchen, bath, and housekeeping responsibilities. The group facility may provide a limited range of services and be licensed or unlicensed.

HAART Highly active antiretroviral therapy. The preferred term for potent anti-HIV treatment. This means a combination of drugs (usually three or more) to combat HIV. Usually more than one class of drug is included in a HAART regimen.

HIV Human Immunodeficiency Virus. The virus that causes AIDS. People infected with HIV may or may not feel or look sick.

HOME HOME Investment Partnership Program. A HUD-administered program providing grants for low-income housing through rental assistance, housing rehabilitation, and new construction.

HOMELESS FAMILY WITH CHILDREN Family that includes at least one parent or guardian and one child under the age of 18; a homeless pregnant woman; or a homeless person in the process of securing legal custody of a person under the age of 18.

HOMELESS PERSON An unaccompanied youth (17 years or younger) or an adult (18 years or older) without children, who is not incarcerated and 1) who lacks a fixed, regular, and adequate nighttime residence; or 2) whose primary nighttime residence is a supervised publicly- or privately-operated shelter; an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for regular sleeping accommodation for human beings.

HOMELESS YOUTH Homeless person 17 years of age or younger who is unaccompanied by an adult.

HOPWA Housing Opportunities for Persons with AIDS. A program of HUD which pays for housing and support services for people living with HIV/AIDS and their families. Created by an Act of Congress in 1990.

HOSPICE A type of support and care provided to people in the last phases of an incurable disease so that they may live as fully and comfortably as possible. Hospice focuses on alleviating pain and discomfort, improving the quality of life, and preparing individuals mentally and spiritually for their eventual death.

HOUSEHOLD A household consists of all the people who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live and eat with any other persons in the structure and there is direct access from the outside or through a common hall.

A household includes related family members and all unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household.

HOUSING UNIT An occupied or vacant house, apartment, or a single room (SRO housing) that is intended as separate living quarters (U.S. Census definition).

HOUSING QUALITY STANDARDS (HQS) Standards set by HUD to ensure that all housing receiving HUD financial assistance meets a certain level of quality. HQS requires that HUD funding recipients provide safe and sanitary housing that is in compliance with state and local housing codes, licensing requirements, and any other jurisdiction-specific housing requirements.

HUD U.S. Department of Housing and Urban Development.

INFORMATION AND REFERRAL Assistance to individuals who are having a difficult time finding and/or securing housing and services.

LOW-INCOME FAMILY Family whose income does not exceed 50 percent of the median income for the area, as determined by HUD, with adjustments for smaller and larger families. HUD may establish income ceilings higher or lower than 50 percent of the median for the area on the basis of HUD's findings that such variations are necessary because of prevailing levels of construction costs or Fair Market Rents, or unusually high or low family incomes.

LOW INCOME HOUSING TAX CREDIT PROGRAM Formula allotment of federal income tax credits administered by states and distributed to developers of and investors in low-income rental housing. Created by the 1986 Tax Reform Act.

MEDIAN INCOME Median household income is the amount which divides the income distribution into two equal groups, one-half having incomes above that amount, one-half having incomes below that amount. The medians for households, families, and unrelated individuals are based on all households, families, and unrelated individuals, respectively. The medians are based on people with income who are 15 years of age and older.

MENTAL ILLNESS, SEVERE A serious and persistent mental or emotional impairment that significantly limits a person's ability to live independently.

MICA Pertaining to a person with both mental illness and chemical addiction.

MODERATE-INCOME An individual or family whose income is between 50 percent and 80 percent of the median income for the area, as determined by HUD, with adjustments for smaller or larger families. HUD may establish income ceilings higher or lower than 80 percent of the median for the area on the basis of HUD's findings that such variations are necessary because of prevailing levels of construction costs or Fair Market Rents, or unusually high or low family incomes.

MULTIPLY DIAGNOSED To be diagnosed with HIV/AIDS and also have histories of other disabilities. This term generally refers to people who are HIV-positive and have chronic alcohol and/or other drug abuse problems and/or a serious mental illness.

NON-HOMELESS PERSONS WITH SPECIAL NEEDS Includes frail elderly persons, persons with HIV/AIDS, disabled families, and families participating in organized programs to achieve economic self-sufficiency (HUD terminology).

OCCUPIED HOUSING UNIT A housing unit that is the usual place of residence of the occupants(s).

OWNER-OCCUPIED A property consisting of fewer than five housing units, at least one of which is occupied by, or within the previous six months was occupied by, a person with an ownership interest in his or his unit, as such person's principal residence.

PERMANENT HOUSING Housing which is intended to be the tenant's home for as long as they choose. In the supportive housing model, services are available to the tenant, but accepting services cannot be required of tenants or in any way impact their tenancy. Tenants of permanent housing sign legal lease documents.

PERSON WITH A DISABILITY A person who is determined to: 1) have a physical, mental, or emotional impairment that is expected to be of long-term, continued and indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that the ability could be improved by more suitable housing conditions; or 2) have a developmental disability, as defined in the Developmental Disabilities Assistance and Bill of Rights Act.

PROJECT-BASED RENTAL ASSISTANCE Rental assistance that is tied to a specific unit of housing, not a specific tenant. Tenants receiving project-based rental assistance give up the right to that assistance upon moving from the unit. (See also glossary definitions for "Rental Assistance," "Shallow Rent Subsidy," and "Tenant-based Rental Assistance.")

PROTEASE INHIBITORS A group of antiretroviral medications for people living with HIV/AIDS including Saquinavir, Indinavir, and Ritonavir. Protease inhibitors act by preventing the replication of HIV in the body and are often prescribed in combination with other HIV medications.

RENTAL ASSISTANCE Cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. HOPWA short term rental assistance is available for up to 21 weeks. HOPWA long-term rental assistance is provided for longer than 21 weeks. Due to HOPWA regulations, rental assistance cannot be guaranteed for longer than three years. Ryan White funds can be used for short-term, transitional, or emergency housing defined as necessary to gain or maintain access to medical care. (See also glossary definitions for "Project-based Rental Assistance," "Tenant-based Rental Assistance," and "Shallow Rent Subsidy.")

RENTER A household that rents the housing unit it occupies, including units both rented for cash and occupied without cash payment of rent (U.S. Census definition).

RENTER-OCCUPIED UNIT Any occupied housing unit that is not owner-occupied, including units rented for cash and those occupied without payment of cash rent.

RYAN WHITE CARE ACT Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. A program of the Health Resources and Services Administration (HRSA) providing funds for health care and supportive services for people living with AIDS. Created by an Act of Congress in 1990.

SECTION 8 A federal program operated by local housing authorities providing rental assistance to low-income persons. The Section 8 *certificate* program typically includes a maximum rent for a metropolitan area or county. Individuals receiving assistance under a certificate program must find a unit which complies with rent guidelines and will pay 30 percent of their income for rent. Under the Section 8 *voucher* program, the local housing authority determines a standard amount of rental assistance an individual or family will receive. The tenant would pay the difference between the amount of assistance and the actual rent, which may require the tenant to spend more than 30 percent of their income on rent.

SERVICE NEEDS The particular services identified for vulnerable populations, which typically may include transportation, personal care, housekeeping, counseling, meals, case management, personal emergency response, and other services to prevent premature institutionalization and assist individuals to continue living independently.

SHALLOW RENT SUBSIDY Short-term or ongoing cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. Typically, shallow rent subsidies are for a set amount and are not related to the percentage of income paid to rent.

SHELTER PLUS CARE A national grant program administered by HUD providing rental assistance, linked with supportive services, to homeless individuals who have disabilities (primarily serious mental illness, chronic substance abuse, and disabilities resulting from HIV/AIDS) and their families.

SHELTERED Referring to families and persons whose primary nighttime residence is a supervised publicly- or privately-operated shelter, including emergency shelters, domestic violence shelters, residential shelters for runaway and homeless youth, and any hotel/motel/apartment voucher arrangement provided because the person is homeless. A facility offering permanent housing is not a shelter, nor are its residents homeless.

SKILLED NURSING FACILITY A nursing home or facility providing 24-hour care from nurses and aides.

SRO Single-Room Occupancy. Refers to studio apartments which provide very limited cooking facilities and typically have shared bathrooms. They are often in rehabilitated hotels and can be used for emergency, transitional, or permanent housing.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) SSDI is a federal government benefit for individuals who are medically disabled and have worked for enough years to be covered under Social Security.

SUBSIDIZED RENTAL HOUSING Assisted housing (see glossary definition) that receives or has received project-based governmental assistance and is rented to low- or moderate-income households. Subsidized rental housing does not include owner-occupied units, nor does it include Section 8 certificate/voucher holders in market rate housing.

SUBSTANTIAL REHABILITATION Rehabilitation of residential property at an average cost for the project in excess of $25,000 per dwelling unit.

SUPPLEMENTAL SECURITY INCOME (SSI) SSI is a federal government benefit for individuals who are 65 years of age or older, or blind, or have a disability and earn a low income.

SUPPORTIVE HOUSING Housing, including housing units and group quarters, which include on- and off-site supportive services.

SUPPORTIVE SERVICES Services provided to residents of supportive housing for the purpose of facilitating the independence of residents. Some examples are case management, medical or psychological counseling and supervision, child care, transportation, and job training.

SYMPTOMATIC Referring to a person who is HIV-positive and who is sick and/or shows medical symptoms of the disease, but who does not have an AIDS diagnosis.

TANF Temporary Assistance to Needy Families. The program which replaced AFDC (AID to Families with Dependent Children).

TENANT-BASED RENTAL ASSISTANCE A form of rental assistance in which the assisted tenant may move from a dwelling unit with a right to continued assistance. The assistance is provided for the tenant, not any specific housing unit. (See also glossary definitions for "Rental Assistance," "Project-based Rental Assistance," and "Shallow Rent Subsidy.")

TRANSGENDERED Individuals whose sense of gender identity does not match their physiological sex, including those who have changed or are in the process of changing their sex from male to female or female to male.

TRANSITIONAL HOUSING A project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living within 24 months, or a longer period approved by HUD. For purposes of the HOME program, there is not a HUD-approved time period for moving to independent living.